WHO contribution in Namibia 2018–2024

Evaluation report

World Health Organization

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Cover page: A picture of a main road in Namibia taken for the Global Road Safety Campaign. © WHO / Julie Pudlowski

Acronyms

AMR	antimicrobial resistance
ART	antiretroviral therapy
CCS	Country Cooperation Strategy
EPR	Emergency Preparedness and Response Cluster
FAO	Food and Agriculture Organization of the United Nations
FCTC	WHO Framework Convention on Tobacco Control
GDP	gross domestic product
GHO	Global Health Observatory
GLASS	Global antimicrobial resistance and use surveillance system
GPW13	WHO's Thirteenth general programme of work
GPW14	WHO's Fourteenth general programme of work
HALE	health-adjusted life expectancy
HiAP	Health in All Policies
HPV	human papillomavirus
ICD	International Classification of Diseases
IDSR	integrated disease surveillance and response
IEC	information, education and communication
IHR	International Health Regulations (2005)
mhGAP	WHO's Mental Health Gap Action Programme
NCD	noncommunicable disease
NDP5	Namibia's Fifth National Development Plan
NDP6	Namibia's Sixth National Development Plan
NHSSP	National Health Sector Strategic Plan
NTD	neglected tropical diseases
OCR	outbreak crisis and response
PEN	Package of Essential Non-Communicable Disease Interventions
PHC	primary health care
RCCE	risk communication and community engagement
RMNCH	reproductive, maternal, newborn, and child health
SDG	Sustainable Development Goal
SRH	sexual and reproductive health
SWAp	sector-wide approach
TB	tuberculosis
UHC	universal health coverage
UN	United Nations
UNAM	University of Namibia
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNPAF	United Nations Partnership Framewo

Executive summary

Introduction

Independent evaluations of the World Health Organization (WHO) contribution at the country level are conducted in line with the WHO Evaluation Policy (2018 and 2025) and implementation framework. In accordance with this, an independent evaluation of WHO's contribution in Namibia was commissioned by the WHO Evaluation Office and the WHO Regional Office for Africa.

The evaluation focused on assessing WHO's contributions to Namibia's health sector under the Country Cooperation Strategy (CCS) III 2018–2024. It aimed to evaluate the added value of its support, and to generate forward-looking recommendations to enhance future collaboration.

WHO has been present in Namibia since the country's independence in 1990. Over the past three decades, WHO has played a significant role in supporting Namibia's health sector, contributing to major public health achievements and milestones.

Evaluation object

The object of this evaluation is to assess WHO's contribution in Namibia, both in terms of results achieved in the CCS III period and its role in implementation of CCS III, and the expected results set out in the biennial work plans. It reflects the coordinated efforts of all three levels of WHO. CCS III targeted four strategic priorities: (1) advancing universal health coverage (UHC), (2) addressing health emergencies, (3) promoting healthier populations, and (4) strengthening leadership and governance. Implementation occurred through biennial workplans developed with Namibia's Ministry of Health and Social Services, with WHO also playing a key role in coordinating development partners and contributing to national and regional health governance. Between 2018 and 2024, WHO invested approximately US$26.7 million to support Namibia's health sector, supporting a wide range of public health initiatives.

Evaluation purpose, objectives and intended audience

The evaluation aimed to strengthen WHO's accountability to the national government and donors, as well as to enhance organizational learning across its three levels. To do so, it assessed the CCS alignment with national health priorities, analysing its achievements and challenges, evaluated its impact and resource adequacy between 2018 to 2024, and identified lessons and recommendations to inform the design and implementation of the next Country Cooperation Strategy (CCS IV). It covered all WHO-supported interventions at national and sub-national levels, drawing on inputs from country, regional, and headquarters levels, and emphasized cross-cutting issues such as gender equality, health equity, and human rights. The primary audience includes the WHO Country Office in Namibia, which

will use the findings to guide strategic and operational planning. WHO regional and headquarters offices, the Ministry of Health and Social Services, United Nations (UN) agencies, development partners, civil society, and non-state actors can also benefit from the insights to strengthen coordination and partnerships.

Methodology

The evaluation adopted a non-experimental design and used a theory-based and utilization-focused approach to assess WHO's contribution to health outcomes in Namibia. The evaluation, conducted using a participatory approach, serves both summative and formative purposes. It examined both what was achieved and the underlying factors influencing those results, aiming to determine WHO's plausible contribution to observed changes. The formative focus reflected in the forward-looking recommendations aimed to improve programmatic planning and delivery and strengthen WHO's strategic positioning and effectiveness in supporting the country's evolving health priorities. The evaluation also serves the dual purposes of learning and accountability to the national Government and to donors. The evaluation was guided by standard criteria—relevance, coherence, effectiveness, efficiency, and sustainability—alongside cross-cutting issues such as human rights, health equity, and gender equality.

Data collection involved both primary and secondary sources. Primary data came from 32 interviews with 55 key informants—80% of whom were female—including representatives from government, UN agencies, civil society, academia, and WHO. Interviews were conducted both in-person in Namibia and remotely with WHO regional and headquarters staff. Secondary data included progress and financial reports from the WHO Country Office in Namibia, as well as a desk review of approximately 50 documents and relevant government databases.

Key findings

Relevance. WHO is the lead UN health agency in Namibia and its contributions are highly relevant by virtue of its positioning, level of engagement and interventions. The contributions aligned well with the national context, health priorities and policies of the Government and responded to the evolving health needs of the Namibian population. CCS III was well aligned with the health and nutrition priorities in Namibia's Fifth National Development Plan (NDP5), including addressing the health and well-being of women, children and adolescents, communicable and noncommunicable diseases to enable individuals and communities to prevent and control communicable and noncommunicable diseases and improve their health. It also explicitly aligned with Sustainable Development Goal (SDG) 3 , GPW 13 and its related goals.

Coherence. Overall, the coherence of WHO interventions and implementation approaches was stronger externally than internally. WHO interventions in Namibia demonstrated some internal coherence by aligning with the four strategic priorities of CCS III. However, the attempt to fully mirror GPW13 led to fragmentation and overstretched resources, as CCS III included an extensive, unprioritized list of 91 interventions without an explicit theory of change. WHO interventions were

well integrated and complementary to the national Government's efforts to advance better health for all and pursue SDG 3 targets. WHO synergized its work with development partners and other UN agencies in Namibia through the Health Development Partners Forum. WHO leveraged its comparative advantage as the lead agency on health within the UN system in Namibia, and among development partners to provide critical technical leadership, particularly during the COVID-19 pandemic. It applied its scientific expertise to advise the country and used its convening power to support the Government in coordinating a cohesive and effective national response. While the previous United Nations Partnership Framework (UNPAF) (2019–2023) was found to have limited joint programming except during emergencies like COVID-19, the new United Nations Sustainable Development Cooperation Framework (UNSDCF) offers a platform to deepen inter-agency cooperation and strengthen joint programming.

Effectiveness. WHO's CCS contributions in Namibia effectiveness were mixed. While it effectively leveraged its normative mandate, its interventions mainly focused on activity and output level, which in some instances plausibly led to outcomes- and system-level changes. Changes at the outcome level cannot be attributed solely to WHO, as the Government of Namibia plays the lead role in financing and implementation, with development partners and WHO contributing to the achievement of results in the health sector.

WHO was notably effective in the first two CCS strategic priorities, namely advancing UHC (Strategic Priority 1) and strengthening Namibia's emergency preparedness (Strategic Priority 2). Under Strategic Priority 1, WHO played a central role in developing and rolling out national quality standards, improving maternal and child health, expanding immunization coverage, and supporting responses to HIV, tuberculosis (TB), and malaria. These efforts contributed to measurable health improvements and demonstrated WHO's strong alignment with national priorities. Similarly, under Strategic Priority 2, WHO effectively supported the development of emergency action plans, early warning systems, and outbreak response mechanisms. Its leadership during the COVID-19 pandemic and the successful containment of the hepatitis E outbreak highlighted its technical and coordination strengths.

However, WHO's support under Strategic Priorities 3 (promoting healthier populations) and 4 (strengthening leadership and governance) encountered certain challenges which limited the extent of the results achieved. Despite efforts to improve nutrition, mental health, and health information systems, progress was uneven. Persistent challenges included underfunding of health promotion, rising tobacco use, and limited access to water and sanitation. Under strategic priority 4, fewer than half of the planned interventions were fully implemented, largely due to structural constraints, such as limited human resources within the WHO Country Office in Namibia and inadequate coordination mechanisms, and to the broad scope and many planned interventions of CCS III. Staffing gaps in the Country Office, including key vacancies and reliance on short-term consultants affected the continuity and consistency of technical support. Additionally, the absence of a clearly articulated theory of change and limited monitoring indicators posed challenges for systematically tracking progress.

Efficiency. WHO's efficiency in delivering support varied across different areas and was significantly influenced by the availability of human and financial resources. WHO's support in Namibia was often

timely, particularly in responding to health emergencies. A clear example is its swift action during the 2017—2022 hepatitis E outbreak, where WHO played a central role in coordinating a multisectoral response, developing a costed response plan, and deploying epidemiologists. This timely intervention contributed to a 97.4% reduction in cases and zero deaths by 2021. Similarly, during the COVID-19 pandemic, WHO rapidly mobilized approximately $3.7 million, supported the establishment of the National Public Health Emergency Operations Centre, and facilitated the procurement of over 1.7 million vaccine doses and essential medical supplies. These actions underscore WHO's operational agility and effectiveness in delivering prompt support during critical periods.

While emergency responses were well-resourced and agile, other strategic priorities—particularly those related to health promotion and noncommunicable disease (NCD)—suffered from underfunding and limited staffing. Strategic Priority 3, for instance, received a notably smaller share of base funding, reflecting its lower prioritization. Moreover, the Country Office faced persistent human resource constraints. Despite a temporary boost in staffing during the COVID-19 pandemic, the office remained heavily reliant on short-term consultants due to a high vacancy rate in permanent positions—largely attributed to protracted recruitment processes. This reliance, while useful in the short term, disrupted continuity, hindered institutional capacity building, and weakened the consistency of technical support provided to the Ministry of Health and Social Services. These structural challenges have, at times, limited WHO's ability to respond as comprehensively as desired to Namibia's evolving health priorities.

Sustainability. The long-term sustainability of WHO's contributions in Namibia depends on continued national investment to implement and scale the policies and strategies developed. WHO contributions strengthened institutional capacities in Namibia, particularly by supporting the development of national health policies and implementation strategies. Its technical assistance and guidance helped embed health priorities into the national development agenda and fostered strong national ownership. WHO was widely regarded as an enabler, supporting the Government's leadership in the health sector. However, the evaluation noted that without adequate government investment, the gains achieved may not be sustained. While institutional frameworks have been strengthened, limited funding and operational capacity at the national level continue to challenge the translation of strategic plans into lasting health outcomes.

Cross-cutting issues. WHO interventions in Namibia address the needs and rights of vulnerable populations primarily at the upstream level by guiding the integration of cross-cutting issues—such as equity, gender, and disability—into national health policies and implementation strategies. These principles are deeply embedded in WHO's mandate and programming in Namibia and were evident across multiple interventions under CCS III. Strategic Priority 1 (UHC) particularly demonstrated a strong focus on health equity, with efforts aimed at improving access to quality care for all, regardless of geographic location. Initiatives to enhance care quality were designed to ensure that all users of the public health system—whether in urban centres or remote rural areas—receive equitable and effective services. These efforts reflect WHO's commitment to inclusive health system strengthening that leaves no one behind.

Conclusions

WHO made a significant and valued contribution in Namibia's health sector during the CCS III period. The Organization effectively leveraged its normative mandate and comparative advantage as the lead UN agency for health, providing timely and credible support—particularly in responding to health emergencies such as the COVID-19 pandemic. WHO remains a trusted and strategic partner of the Government of Namibia, contributing meaningfully to national health priorities and systems strengthening. The evaluation identified multiple successes across strategic priorities, while also highlighting areas for improvement, particularly in resourcing, coordination, and continuity of technical support.

Conclusion 1

WHO reinforced its strategic positioning as the leading health agency in Namibia by building on its longstanding partnership with the Government, particularly through the Ministry of Health and Social Services. Its continuous engagement with government counterparts—at both the political and administrative levels—enhanced its role as a trusted adviser on key health issues. WHO's support remained highly relevant and aligned with Namibia's national health and development priorities throughout the CCS III period. The profile of WHO was significantly elevated during the COVID-19 pandemic, when its comparative strengths in mobilizing resources—specifically during health emergencies—and convening diverse stakeholders were clearly demonstrated. WHO's leadership and technical guidance during the crisis further solidified its position as a critical partner in Namibia's health landscape.

Conclusion 2

WHO was effective in achieving results over the CCS III period, although the extent of success varied both across and within Strategic Priorities. Notably, positive changes were observed in the CCS outcome indicators for Namibia in Strategic Priority 1 (UHC) and Strategic Priority 2 (health emergencies). These areas received the majority of WHO's financial and human resource investments, making it plausible that WHO contributed significantly to the progress achieved. In contrast, progress under Strategic Priority 3 (promoting healthier populations) was limited. While the COVID-19 pandemic posed a significant challenge, the persistent under-resourcing of Strategic Priority 3 throughout the CCS III period was a key constraint to achieving intended outcomes. To maximize impact, WHO should leverage the UNSDCF and better align its health interventions with broader UN efforts, promoting integrated and multisectoral approaches to health and development in Namibia.

Conclusion 3

By the end of 2024, a substantial agenda from CCS III remained unfinished, such as human resources development, strengthening health information systems and e-health, procurement capacity, progress toward UHC, NCD prevention and malaria elimination, reducing child malnutrition, and scaling up adolescent-friendly and gender-based violence services—largely due to resource constraints. A significant decline in external (donor) funding limited the Government's capacity to implement the policies and strategies developed with the support of WHO and other development partners. This reduction in financial support contributed to the slow progress in translating strategic guidance into concrete action. The recent precipitous reduction in some donor's development assistance funding presents challenges for the country and its health sector, as well as opportunities for WHO to discuss with national counterparts the types of assistance required.

Conclusion 4

CCS III was ambitious in scope and designed more as an operational framework than a strategic framework/plan to guide actions. Furthermore, the CCS was not grounded in an explicit theory of change, and the accompanying monitoring and evaluation framework lacked intermediate outcome indicators. This limited the ability to clearly demonstrate WHO's contribution to improvements in the health sector.

Conclusion 5

Country Office staffing was not commensurate with the extensive portfolio of planned CCS III interventions. Prolonged vacancies in senior positions placed additional workload on existing staff, requiring them to assume multiple roles beyond their core responsibilities. The reliance on short-term consultants to supplement the limited number of permanent positions created discontinuities in both implementation and sustained engagement with government ministries, departments, and agencies.

Recommendations

Ensuring continuity between CCS III and CCS IV

Strategic and results-oriented development of CCS IV (2026–2030)

Recommendation 1: WHO in collaboration with the Ministry of Health and Social Services and other key health stakeholders should develop and finalize CCS IV (2026–2030) by the fourth quarter 2025, aligning with Namibian National Development Plan health priorities and WHO's Fourteenth general programme of work (GPW14) strategic outcomes where it has a clear comparative advantage in the country. Furthermore, CCS IV should contain a robust Theory of Change and monitoring and evaluation framework that includes intermediate outcomes and indicators to better capture results that can be attributed to WHO. To operationalize this recommendation, specific actions include:

- Establishing strategic focus and causal pathways for CCS IV
- Aligning CCS IV with national and global health priorities

- Strengthening monitoring and evaluation to demonstrate WHO's contribution
- Strengthening alignment and adaptation through joint planning and review
- Reviewing and adapting the CCS for continued relevance and responsiveness

Strengthening Equity and Impact through scaled support to under-resourced health priorities

Recommendation 2: WHO should consolidate gains in well-performing areas while scaling up support in under-resourced domains to enhance outcome- and system-level impact. This includes maintaining momentum in UHC and emergency preparedness, while intensifying efforts in NCDs, health promotion, and health information systems. Priority actions and resource planning for these areas should be initiated in the first year of CCS IV implementation (2026) and reviewed annually to ensure continued relevance and progress. To do this, specific actions include:

- Strengthening UHC implementation planning
- Enhancing health information systems and data use
- Collaborating with the Ministry of Health and Social Services to develop and implement a costed national action plan for NCD prevention and control
- Reinforcing the implementation and monitoring of communicable disease action plans

Implementing CCS IV (2026–2030)

Strengthen collaboration with UN agencies and multistakeholder and multisectoral partnerships

Recommendation 3: WHO should strengthen its collaboration with UN agencies contributing to relevant health outputs under the UNSDCF and expand multisectoral partnerships beyond the Ministry of Health and Social Services over the next 12–18 months. This includes supporting joint actions, advocating for integrated approaches to health, and actively engaging with other sectors. To operationalize this recommendation, specific actions include:

- Promoting joint UN collaboration Supporting sector coordination and Health in All Policies (HiAP)
- Strengthening engagement with non-State actors
- Improving intra-ministerial coordination
- Advocating for increased and equitable allocation of the national budget to the health

Strategically align and optimize human and financial resources for enhanced Impact

Recommendation 4: To ensure efficiency and impact, the Country Office should optimize the use of its financial and human resources over the next two years. To do so, it should strengthen the strategic allocation and monitoring of resources by aligning staffing and budgets with priority health outcomes, enhancing planning processes and resource mobilization, and regularly reviewing resource utilization. To do this, specific actions include:

- Conducting a strategic workforce review
- Increasing funding for under-resourced areas
- Enhancing financial monitoring and efficiency

More specific details on the actions to implement the above-mentioned recommendations are listed on pages 42, 43 and 44.

1 Introduction

1.1 Background and national context

Background

Independent evaluations of WHO contribution at the country level are conducted in line with the WHO Evaluation Policy (1), the Implementation framework of WHO evaluation policy (2), and the Framework for evaluations of WHO's contribution at country level (3). These evaluations focus on the outcomes and results achieved at the country level through inputs from all three levels of the Organization. They assess WHO's contributions to addressing the country's public health needs and the objectives in WHO's general programme of work and key strategic documents, the CCS, Country Office work plans, and national health strategies. Country-level evaluations are included in the biennial WHO organization-wide evaluation work plan, approved by the Executive Board.

Political and socio-economic context

The Republic of Namibia gained independence in 1990 and has made significant social and economic progress since independence. Economic growth improved in the post-COVID-19 period to 4.2% in 2023, with growth projected to slow down slightly from 2024 through 2026 to 3.0–3.8%.

Namibia has a population of approximately 3.02 million people, relatively young, with 71.1% of the population under the age of 35 years, and females comprising 51.27% of the population. The population is equally distributed between rural and urban locations and is projected to increase to 4 million by 2050. The country is sparsely populated with 3.47 persons per square kilometre (5).

Namibia exhibits characteristics of other lower middle-income countries in the Southern Africa region, namely, significant levels of poverty and inequality. Poverty is greater in rural areas (37%) than urban ones (15%) and higher among women (32%) than men (26%). According to the 2021 Multidimensional Poverty Index, 43.3% of the Namibian population are multidimensionally poor. Namibia's Gini index of 63.3 in 2022, is one of the highest globally. Unemployment remains at 19.63% in 2023 (6), but the Government expects initiatives such as the US$ 10 billion Green Hydrogen project to create up to 15 000 jobs and make inroads into unemployment (7).

Namibia has integrated the SDGs into its National Development Plan with its five pillars: Economic Progression, Social Transformation, Environmental Sustainability, and Good Governance, and in the sector plans of the Government. The country submitted its third voluntary national review in 2024, which concluded that Namibia had made some progress in the implementation of the SDGs, but several challenges had to be addressed to accelerate progress towards achievement of SDG targets. These challenges include the recurring impacts of climate change that retard or reverse progress in national development; the limited fiscal space resulting in the Government spreading thinly across many interventions, delaying the completion of projects; and gaps in monitoring and evaluation and

data systems, posing a challenge to assessing national performance, including progress in implementing the SDGs (7).

Namibia's health sector is governed by a relatively limited legislative framework, with the National Health Act 2 of 2015 (8), yet to be fully enacted. Although it provides for the consolidation of health laws and a comprehensive national health system, only the appointment of the Chief Health Officer has been operationalized. The Public and Environmental Health Act 1 of 2015 (9), fully in force after COVID-19, aims to promote public health, prevent diseases, and encourage community participation in health. The Hospital and Health Facilities Act of 1994 (10) governs public and private hospitals, while the Health Professions Act 16 of 2024 (11) regulates health professional registration and licensing through the Health Professions Council. Additionally, the Medicines and Related Substances Control Act of 2003 (12) ensures the quality and safety of medicines.

Namibia's health priorities were outlined in NDP5 (2017/18–2021/22), focusing on increasing health-adjusted life expectancy (HALE) through human resources development, improved medical equipment, emergency services, and tackling public health threats, pharmaceuticals access, infrastructure, and health information systems. NDP6 is under development and will align with Vision 2030.

Strategic policy direction has been guided by the National Health Policy Framework 2010–2020 and the Ministry of Health Strategic Plan 2017/18–2021/22, emphasizing people-centred care, health equity, and primary health care (PHC). A revised National Health Policy Framework (2024/25–2030)—awaiting endorsement—prioritizes six strategic areas including UHC, service coverage, social determinants, and health security.

Namibia also implements multiple thematic plans, such as:

- the NCD Strategic Plan, the Mental Health Policy, and the Sexual, Reproductive and Child Health Policy;
- the eHealth Strategy, the National Action Plan for Health Security, and the Neglected Tropical Diseases (NTD) Master Plan;
- the Quality Management and Infection Prevention plans;
- the National Medicines Policy, the National Action Plan on Antimicrobial Resistance , and the Drug Control Master Plan; and
- the Road Safety Strategy and the Integrated School Health and Safety Policy.

These plans, strategies, and policies collectively aim to address a wide range of health priorities including health promotion, disease control, health system strengthening, and emergency preparedness.

Namibia's health profile

Public health services in Namibia are provided through one national referral hospital, four intermediate hospitals, 36 public district hospitals, 43 health centres, 302 clinics and over 1000 outreach points. Access to health services is notably good, with 76% of the population living within the WHO-recommended 10 km radius of a health facility. The health worker-population ratio of

3.0 : 1000 has remained consistently above the WHO benchmark of 2.5 : 1000. However, the available health workforce is skewed towards urban areas and the private sector, with the private sector accounting for 62% of the health workforce and serving 20% of the population *(13)*.

The health system is funded predominantly through tax revenue, and government per capita expenditure on health stands at US$ 217. Government health expenditure stands at about 4.45% of Namibia's GDP and represents 48% of total current health expenditure. The UHC service coverage index for Namibia in 2021 was estimated at 63 *(14)* up from 59 in 2017 *(15)*.

Life expectancy in Namibia improved between 2015 and 2020 for both sexes (from 64.8 to 67.1 years for females; from 58.8 to 60.0 years for males). Similar improvements were recorded for HALE between 2015 and 2020 (from 55.9 to 57.8 years for females; from 52.3 to 53.6 years for males) *(16)*. These HALE improvements might be partially attributable to Namibia's HIV/AIDS programme success, having over 90% of people living with HIV knowing their status, over 90% of people living with HIV who know their status receiving antiretroviral treatment (ART), and over 90% of those on ART having a suppressed viral load *(17)*. Detailed statistical information on Namibia's population and health profile is contained in Annex 6.

The COVID-19 pandemic had a significant impact on the health of Namibia's population. In 2021, life expectancy declined to 60.4 years (63.4 for females; 57.3 for males) and HALE declined to 52.8 years (54.6 for females; 51.0 for males). COVID-19 was the leading cause of death for females and males in 2021, followed by tuberculosis and HIV/AIDS *(16)*.

Namibia has seen a reduction in the incidence of tuberculosis between 2000 and 2023, from 985 cases per 100 000 population [95% CI 469 – 1690] to 468 cases per 100 000 population [95% CI 221 – 622] *(16)*. This incidence however remains higher than that of the Africa region (206 cases per 100 000 population).

The rate of new HIV infections has declined steadily from the peak of 14 per 1000 uninfected population in 1997 to 2.2 in 2023, underscoring the positive results yielded by HIV/AIDS interventions. The estimated number of new infections declined from 13 000 in 2011 to 6000 in 2023. Estimated ART coverage (all ages) in 2023 was 89%, with 202 605 people reporting receiving ART.

The country faces a triple burden of disease with communicable diseases as the leading cause of death but with an increasing trend from NCDs and injuries as causes of death *(18)*.

1.2 Evaluation object

WHO country programme in Namibia

The object of the evaluation is WHO contribution in Namibia, both in terms of results achieved in the current strategic period, and in terms of its role going forward. It reflects the coordinated efforts of all three levels of WHO. CCS III (2018–2024)[1] captures the planned results and interventions for the WHO

[1] The CCS was originally planned to cover the period 2018–2022, but was extended to 2024, in line with the extension of UNPAF 2019–2023 to 2024.

Country Office in Namibia. It sets out the medium-term vision for WHO's technical cooperation with Namibia and supports the country's national health strategy. CCS III is implemented through biennial workplans developed in close consultation with Namibia's Ministry of Health and Social Services.

CCS III has four strategic priorities:

- Strategic Priority 1: Advancing UHC
- Strategic Priority 2: Addressing health emergencies
- Strategic Priority 3: Promoting healthier populations
- Strategic Priority 4: Strengthening leadership, governance and enabling functions.

The first three strategic priorities are interrelated and focus on interventions that contribute to improving the health and well-being of all people in Namibia, while the fourth priority addresses the enablers for WHO to fulfil its mandate.

The development of CCS III was informed by the priorities identified in the Namibia National Health Sector Strategic Plan (2017–2022) (NHSSP) and a national consultation processes, UNPAF 2019–2023, and WHO's Thirteenth general programme of work 2019–2025 (GPW13).

Table 1 sets out the planned outcomes and focus areas for each CCS III strategic priority. The CCS III strategy document includes a country results framework that sets out targets and indicators based on the GPW13 Planning and Budgeting Framework, the UNPAF, and the NHSSP. These targets and indicators are linked to the outcomes of Strategic Priorities 1, 2 and 3 to enable assessment of progress and impact.

The WHO Country Office in Namibia has supported Ministry of Health and Social Services leadership in their engagement in WHO governing bodies meetings, including the WHO Regional Committee for Africa and the World Health Assembly. In addition, the Country Office is a member of the United Nations Country Team and collaborates with other UN agencies including the Joint United Nations Team on AIDS, the Gender Theme Group, and the Emergency and Humanitarian Thematic Group. The Country Office chairs the Health Development Partners Forum that it established in 2011, with the aim of improving information sharing, coordination, and collaboration among development partners in their support to the Ministry of Health and Social Services.

Table 1: CCS III strategic priorities, outcomes, and focus areas[a]

Strategic priority and target	Outcomes	Focus areas
1. Advancing UHC **(more people with health coverage)**	1.1 Improved access to quality essential health services	1.1.1 Health systems strengthening 1.1.2 Reproductive, maternal, neonatal, child and adolescent health and nutrition 1.1.3 Communicable and NCDs.
	1.2 Reduced number of people suffering financial hardship	1.2.1 Health financing 1.2.2 Effective partner coordination 1.2.3 Mobilization and management of resources
	1.3 Improved availability of essential medicines, vaccines, diagnostics and devices for PHC	1.3.1 Procurement and supply of essential medical products 1.3.2 Provision of essential equipment

2. Addressing health emergencies **(more people made safer)**	2.1 Country health emergency preparedness strengthened	2.1.1 Implementation of International Health Regulations (2005) (IHR)
	2.2 Emergence of high threat infectious hazards prevented	2.2.1 Integrated disease surveillance and response and IHR
	2.3 Health emergencies rapidly detected and responded to	2.3.1 Institutional strengthening 2.3.2 International Classification of Diseases (ICD)
3. Promoting healthier populations (**more people's lives/health improved)**	3.1 Determinants of health addressed leaving no one behind	3.1.1 Nutrition 3.1.2 Environmental health 3.1.3 Sexual and reproductive health (SRH)
	3.2 Reduced risk factors through multisectoral approaches	3.2.1 Physical activity 3.2.2 Diet 3.2.3 Substance abuse
	3.3 Health promotion in all policies and settings	3.3.1 HiAP 3.3.2 NCDs and conditions
4. Strengthening leadership, governance and enabling functions	4.1 Strengthened data and innovation	4.1.1 Research 4.1.2 Health information systems 4.1.3 Monitoring and evaluation

[a] Source: WHO Country Office in Namibia CCS III *(19)*.

In the context of the SDGs, GPW13 provided a vision of a world where all people attain the highest possible standard of health and well-being *(20)*. GPW13 summarizes WHO's mission to promote health, keep the world safe, and serve the vulnerable. The goal of GPW13 is to ensure healthy lives and promote well-being for all ages by (a) enabling one billion more people to achieve UHC, (b) protecting one billion more people from health emergencies, (c) empowering one billion more people to enjoy better health and well-being. Thus, the three GPW13 strategic priorities included advancing UHC, addressing health emergencies, and promoting healthier populations. The CCS III strategic priorities wholly aligned with those of GPW13.

WHO envisioned driving public health impact in every country through a differentiated cooperation approach based on capacity and vulnerability. Planned key strategic shifts to deliver on the GPW13 promise included the following: (1) increased leadership in diplomacy and advocacy, gender equality, health equity and human rights, multisectoral action, and finance); (2) policy dialogue to develop systems of the future; (3) strategic support to build high performing systems; (4) technical assistance to build national institutions; (5) service delivery to fill critical gaps in emergencies; and (6) focusing global public goods on impact (normative guidance and agreements, data, research and innovation) *(20)*.

Funding of WHO Country Office in Namibia programmes

As shown in Table 2, the total planned cost (amount budgeted) for the WHO Country Office in Namibia was US$ 46 229 928, with a total work plan funding (funds available) of US$ 29 024 837, and a total expenditure (including encumbrances) of US$ 26 706 962 over the 2018–2024 period (Table 2). The base segment received 68% of the total workplan funding (funds available) as it covers interventions related to the four CCS III strategic priorities. In addition to the base, 4% of the total workplan funding

was for polio eradication, 26% for outbreak crisis and response (OCR), and 2% for the Expanded Special Project for the Elimination of Neglected Tropical Diseases (ESPEN).

Table 2: Funds received and utilized by the WHO Country Office in Namibia 2018–2024[a]

	2018–2019		2020–2021		2022–2023		2024		Total period (2018–2024)	
Budget segment	Funds received[b] (US$)	Funds utilized[c] (US$)	Funds received (US$)	Funds utilized (US$)	Funds received (US$)	Funds utilized (US$)	Funds received (US$)	Funds utilized (US$)	Funds received (US$)	Funds utilized (US$)
Base (WHO core mandate)	3 980 162	3 708 074	4 206 528	4 113 450	6 755 320	6 360 836	4 776 158	3 655 633	19 718 168	17 837 993
Polio eradication	623 707	594 984	163 772	121 389	197 853	195 149	135 266	99 314	1 120 598	1 010 836
OCR	192 578	192 576	3 546 202	3 287 197	3 501 837	3 860 831	386 217	8 074	7 626 834	7 348 678
ESPEN	59 620	53 683	43 842	0	182 653	182 652	273 122	273 120	559 237	509 455
TOTAL	4 856 067	4 549 317	7 960 344	7 522 036	10 637 663	10 599 468	5 570 763	4 036 141	29 024 837	26 706 962

[a] Source: WHO Country Office in Namibia (April 2025).
[b] Funds received is the same as workplan funding or funds available.
[c] Funds utilized includes expenditure and encumbrances.

Out of the total workplan funding (funds available) of US$ 29.03 million, 31% was allocated to CCS III Strategic Priority 1 (advancing UHC), 12% to Strategic Priority 2 (addressing health emergencies), 7% to Strategic Priority 3 (promoting healthier populations by addressing social determinants of health and risk factors), 18% to Strategic Priority 4 (strengthening WHO leadership, governance and corporate enabling functions), 4% to polio eradication, 26% to OCR, and 2% to ESPEN. Thus, the interventions aimed at improving health system performance (provision of essential health services) were allocated the highest share (31%) of the funds received (workplan funding).

The Country Office received 63% of the planned (budgeted) cost for implementing CCS III interventions, amounting to US$ 29 024 837. Of this, US$ 26.7 million was spent (92% implementation rate), implying that 8% (US$ 2 317 875) of the funds received were unspent. As shown in Table 2, the implementation rate for 2018–2019 was 93.7%, with 94.5% for 2020–2021, 99.6% for 2022–2023, and 72.5% for 2024. About 66.2% (US$ 1 534 622) of the unspent workplan funding (received funds) was for the first year of 2024–2025 and will likely be spent during the second year. Thus, for the three biennia, only US$ 783 253 was unspent.

As shown in Table 3, out of the total US$ 26 706 962 spent by the Country Office between 2018 and 2024, 32% was spent on Strategic Priority 1, 11% on Strategic Priority 2, 5% on Strategic Priority 3, 19% on Strategic Priority 4, 4% on polio eradication, 27% on OCR, and 2% on ESPEN. The implementation rate of the base budget (funds received) varied between 70% (Strategic Priority 3) and 96% (Strategic Priority 1). Even though most of the funds received were initially allotted to Strategic Priority 1, the interventions aimed at preparing and responding to public health emergencies incurred the largest share in saving lives (38%). The implementation rates for polio, OCR, and ESPEN funds were 90% or greater.

Table 3: WHO Country Office in Namibia workplan funding and implementation rate 2018–2024[a]

Category	Planned cost/ amount budgeted (US$) (A)	Workplan funding / Funds available (US$) (B)	Utilization[b] (US$) (C)	Implementation rate (%)[c] (D)
Strategic Priority 1: Advancing UHC	17 371 867	9 080 399	8 675 808	96
Strategic Priority 2: Addressing health emergencies	5 699 430	3 445 852	2 837 590	82
Strategic Priority 3: Promoting Healthier Populations	4 908 642	1 897 404	1 326 145	70
Strategic Priority 4: Strengthening Leadership, Governance, & Enabling Functions	7 014 032	5 294 513	4 998 449	94
Base Total	**34 993 971**	**19 718 168**	**17 837 993**	90
Global Polio Eradication Initiative	1 171 912	1 120 598	1 010 836	90
OCR: Health Emergencies Rapidly detected and responded to	9 033 712	7 626 834	7 348 678	96
ESPEN	1 030 333	559 237	509 455	91
TOTAL (US$)	**46 229 928**	**29 024 837**	**26 706 962**	**92**

[a] Source: WHO Country Office in Namibia (April 2025).
[b] Utilization was calculated as expenditure plus encumbrances.
[c] Implementation rate was calculated as $D = (C/B) \times 100$.

A small number of development partners (donors) provided financial and technical support. These included the Government of Japan, Sight Savers, the United Nations Office for Project Services, the Government of Iceland, and the Ministry of Foreign Affairs of the Republic of Korea.

1.3 Evaluation purpose, objectives and scope

The evaluation of WHO contribution serves two main purposes:

- to strengthen accountability for results towards WHO external and internal stakeholders;
- to enhance organizational learning by generating insights and lessons to inform the development of the next CCS.

The evaluation had six objectives:

- to assess the extent of alignment of WHO's work to Namibia's national health strategies, priorities and evolving needs;
- to analyse the key achievements of WHO against the objectives formulated in the CCS III and corresponding expected results developed in Country Office biennial work plans, while pointing out the key success factors, gaps, challenges, and opportunities for improvement;
- to assess WHO's work on driving impact at country level and contribution towards enhancing public health;

- to identify lessons learned from WHO's work, to inform development and resourcing of the next CCS IV and operational planning;
- to assess the adequacy of WHO resources (human, financial) to attain set targets and make impactful contribution to the health agenda of the country; and
- to recommend required programmatic adjustments to realize a fit for purpose WHO to enhance the impact and relevance of WHO's work in Namibia.

The evaluation scope covered all interventions undertaken by WHO in Namibia, from all three levels of the Organization: country office, regional office, and headquarters. It covered the period 2018–2024, as defined in the CCS for Namibia. The geographic scope was national, that is, all interventions undertaken by WHO in the capital, as well as interventions outside the capital. The evaluation assessed cross-cutting issues of gender equality, health equity and human rights.

The evaluation covered three biennia, namely, 2018–2019, 2020–2021, and 2022–2023 and 2024. This coincides with the last year of the Twelfth general programme of work (2014–2019) and GPW13 (2019–2025). As most of the CCS III period fell within GPW13, the evaluation focused on this GPW. The evaluation focused on results at the outcome level of the CCS and drew on the products and services reported in the biennium reports to assess WHO's contribution at the outcome level. The evaluation did not cover each activity in detail as this was already covered in biennium reports from the WHO Country Office in Namibia.

The Country Office is the primary user of the evaluation as the results of the evaluation will guide the development of the next CCS and the next biennium plan. The Regional Office and headquarters can use the insights from the evaluation to inform their work in supporting WHO country offices and Member States. Findings on coordination across the three levels of the Organizations can be useful to efforts to enhance WHO internal coordination.

The Ministry of Health and Social Services, as the primary counterpart has an interest in the evaluation, and the findings provide an independent assessment of WHO's contribution in Namibia. In addition to serving as an accountability tool, the Ministry can use the evaluation findings to enhance its engagement with WHO for the benefit of the country. UN agencies in Namibia can use the findings to strengthen collaboration and identify new opportunities for collaboration. Other development partners, civil society partners, and non-state actors can use the evaluation findings to enhance their understanding of WHO's contribution and opportunities for strengthening partnerships.

1.4 Evaluation questions and criteria

The main evaluation questions proposed in the Terms of Reference (Annex 1) were reviewed and adjusted for clarity during the inception phase and then presented and validated in the inception report. The evaluation questions are aligned with the Organisation for Economic Co-operation and Development's Development Assistance Committee criteria, namely, relevance, coherence, effectiveness, efficiency and sustainability. An additional question on cross-cutting issues of human

right, gender and health equity was included. The final five evaluation questions (Table 4) were elaborated further into 10 sub-questions framed in the evaluation matrix in Annex 2.

Table 4: Evaluation criteria and evaluation questions

Relevance	**EQ 1**. To what extent is the Country Office's positioning, level of engagement, and interventions aligned to the national context and the evolving needs, policies, and priorities of the Government, and to the needs and rights of Namibians?
Coherence	**EQ 2.** To what extent have WHO interventions and implementation approaches integrated and demonstrated synergies and complementarity with one another as well as with interventions carried out by the Government and other partners in Namibia?
Effectiveness and Efficiency	**EQ 3.** To what extent were WHO results (including contributions at the outcome and system level) achieved or are likely to be achieved and what factors influenced (or did not influence) their achievement?
Sustainability	**EQ 4.** To what extent has WHO contributed towards building sustainable national capacity of institutions and relevant government structures to lead the health development agenda?
Cross-cutting issues	**EQ 5.** To what extent did WHO address the needs and rights of vulnerable populations, especially those at risk of being left behind?

2 Methodology

2.1 Evaluation methodology and approach

Theory-based approach

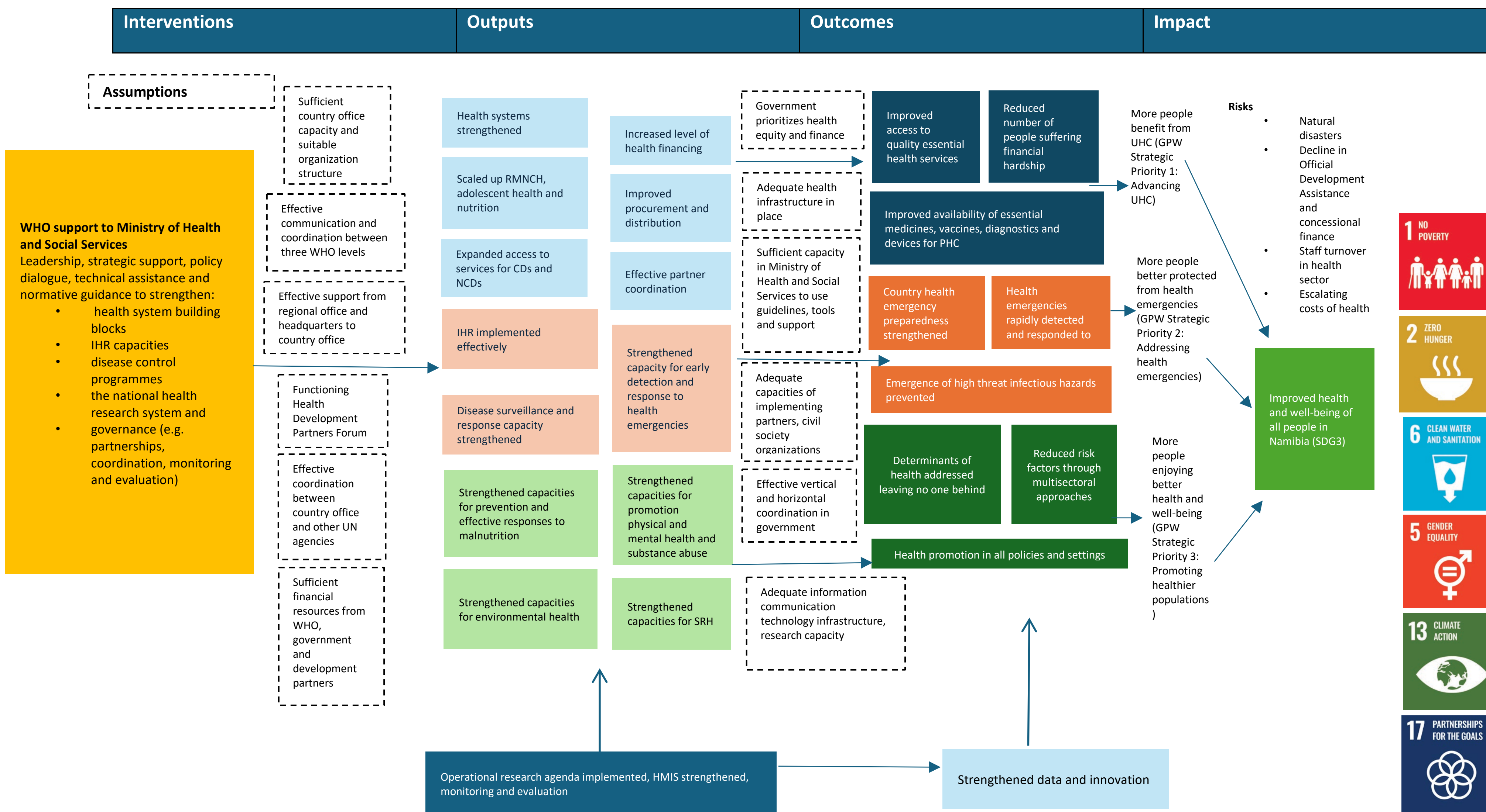
To address the evaluation questions, the team adopted a blended methodological approach. The evaluation used a non-experimental design and applied a theory-based and utilization-focused approach to assess WHO's contribution to health outcomes in Namibia from 2018 to 2024. Conducted through a participatory process, the evaluation served both summative and formative purposes, ensuring stakeholder engagement and practical use of findings for decision-making. Evaluation questions were mapped to the theory of change to enable testing of the change pathways during the evaluation. Fig. 1 provides a diagrammatic representation of the theory of change, which was shared with the Country Office during the field mission.[2] Additional information on the theory of change is in Annex 3.

The theory of change identifies the expected results of the interventions implemented under CCS III. These results are first identified at the output (products and services) level, and if these output level results are achieved, then they will contribute to the achievement of CCS III outcomes in the four strategic priorities. Over the longer term, progress or achievements at the outcome level will contribute to progress towards the SDGs, with emphasis on SDG 3. To achieve progression from

[2] The Country Office noted the usefulness of the theory of change and indicated that it would be beneficial to construct a theory of change for the next CCS.

interventions, to outputs, to outcomes, to impact, certain conditions and assumptions need to be in place. Examples of these include capacity of the Country Office, coordination between the headquarters, regional, and country levels of WHO, sufficient financial resources from the Government and development partners, coordination within the health sector, and Government prioritization of health equity.

Figure 1: Draft theory of change

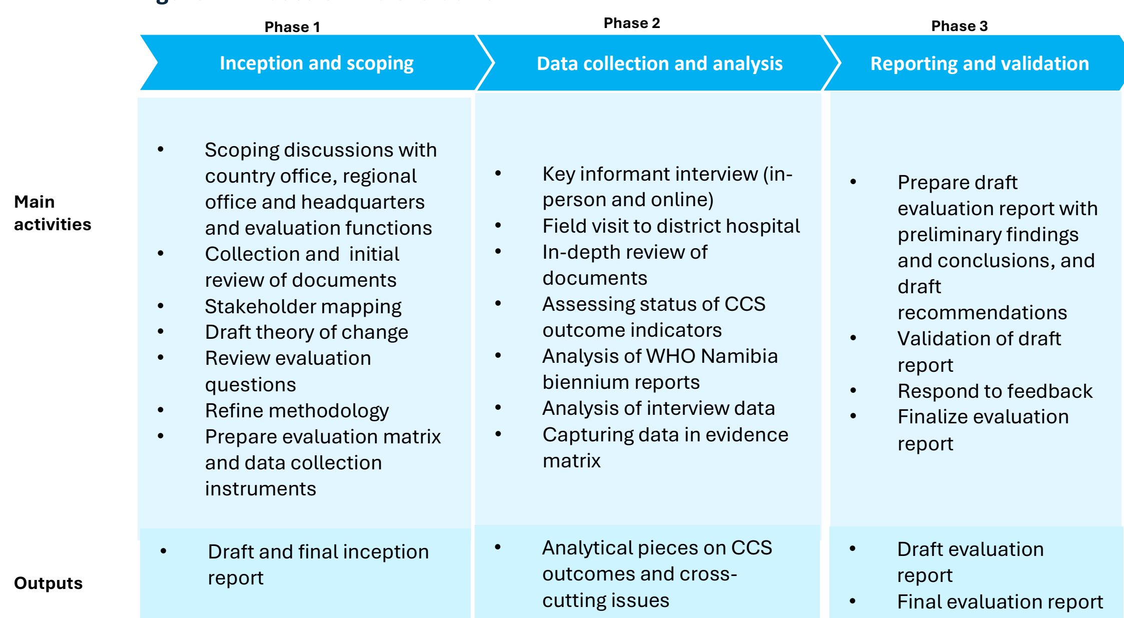


The evaluation assessed the effectiveness of WHO's contribution primarily at the outcome level. As outlined in the inception report, attributing changes at this level solely to WHO is neither feasible nor appropriate. Instead, the evaluation examined WHO's contribution within the broader context of efforts by other UN agencies, the Government, and development partners.

Phases of the evaluation

The evaluation was conducted in three phases (Fig. 2). Primary data were collected through semi-structured in-person interviews in Namibia from 18 to 29 November 2024 and online interviews with from December 2024 to February 2025. Staff at the Country Office, Regional Office, and WHO headquarters were interviewed. The selection of the sample of key informants was purposive, informed by their roles in the implementation of WHO's work in Namibia. The evaluation team also visited the district hospital in Opuwo in the Kunene region of north-west Namibia and interviewed teams of health professionals and observed the hospital facilities. A total of 32 interviews involving 55 persons (80% female) were conducted. The details of interviews are contained in Annex 4 and data collection tools are contained in Annex 5.

Figure 2: Phases of the evaluation



The secondary data included Country Office plans and reports, policy and strategy documents of the Ministry of Health and Social Services, and documents from UN agencies and development partners in Namibia. Data were also extracted from databases including the WHO Global Health Observatory (GHO). Further, the evaluation team reviewed approximately 50 documents. Key references not directly cited in this report are listed in Annex 7.

Data analysis

The evaluation used a mixed methods research design to collect and analyse quantitative and qualitative data. CCS III outcome indicators achievement status were collated from various secondary

sources and analysed quantitatively using Excel software to see the trend between 2018 and 2024. Since CCS III did not have monitoring indicators for the planned 91 interventions, the level of implementation (fully implemented, partially implemented, not implemented, or no information) was qualitatively judged based on the Country Office's reported delivery of pertinent products and services. A qualitative thematic (according to the questions posed) analysis of the information collected through interviews of the key informants was done using the Excel software.

The evaluation applied triangulation across data sources, methods, and perspectives to enhance validity and reliability. Evidence from document reviews, key informant interviews, and quantitative data was cross-checked to confirm findings and reduce bias.

2.2 Ethical considerations

The evaluation team sought consent from interviewees at the start of the interviews and provided assurance of confidentiality and anonymity. WHO Country Office staff were not present in any of the interviews and group discussions conducted. The interview notes have been retained by the evaluation team and will be made available to the WHO Evaluation Office only for storage in electronic form.

2.3 Limitations, risks and mitigation

Results framework incompleteness

The CCS III results framework included measurable outcome indicators but lacked output-level indicators, which made it challenging to assess WHO's specific contribution to progress at the outcome level. To address this gap, the evaluation undertook a detailed analysis of all the interventions implemented during the CCS III period, examining their level of completion and the extent to which the Ministry of Health and Social Services utilized their outputs, such as policies and strategies. Rather than attributing change solely to WHO, the evaluation assessed WHO's contribution within the broader context, recognizing the roles played by development partners and other UN agencies.

Limited stakeholder engagement during data collection

The in-country data collection took place over two weeks towards the end of the calendar year. The evaluation team prioritized interviews with government and development partners during the field mission and met with the staff of the Country Office. Due to time constraints, individual meetings with technical teams were not feasible during the mission; however, this was addressed through follow-up virtual discussions with all technical teams to gather the necessary information. While interviews with all Regional Office clusters could not be secured due to scheduling conflicts, most provided written input in response to the interview questions, which was adequate for the purposes of the evaluation.

Absence of a Results Monitoring System

The evaluation faced a major challenge due to the absence of a functional results monitoring system, which hindered the ability to link completed activities to key performance indicators. To address this, the evaluation relied on secondary data sources and key informant interviews to triangulate findings and provide contextual insights in the absence of structured monitoring information.

3 Findings

3.1 Relevance

Key evaluation question 1. To what extent are the Country Office's positioning, level of engagement, and interventions aligned to the national context and the evolving needs, policies, and priorities of the Government, and to the needs and rights of Namibians?

Finding 1. WHO's positioning, level of engagement and interventions were highly aligned with the national context, evolving needs and policies of the Government and the people of Namibia.

WHO engaged in an extensive and rigorous process to identify the priorities for CCS III. This included a series of dialogues and consultation with the Government of Namibia, health development partners, civil society organizations, academia and other stakeholders in the health sector. CCS III priorities were also informed by an analysis of Namibia's health and development situation and a review of the previous CCS, which had generated lessons for WHO. The review of CCS II identified the 'unfinished agenda' to be taken forward in CCS III, such as human resources development; strengthening health information systems and e-health; procurement capacity; progress toward UHC; NCD prevention and malaria elimination; reducing child malnutrition; scaling up adolescent-friendly and gender-based violence services; and enhancing IHR implementation, food safety, health promotion, and water, sanitation, and hygiene. The consultations and dialogues ensured that CCS III aligned with national health priorities and entrenched joint ownership of and responsibility for CCS III by WHO and the Government of Namibia.

The feedback from key informants on the relevance of WHO's CCS priorities was consistent across all categories of stakeholders. The National Health Policy Framework 2010–2020 and the Ministry of Health and Social Services National Strategic Plan 2017/18–2021/22 prioritized PHC, health equity and health systems strengthening. These priorities are reflected in CCS III, in particularly in Strategic Priority 1. CCS III is aligned to priorities in NDP5's health and nutrition pillar, including addressing the health and well-being of women, children and adolescents, as well as communicable and noncommunicable diseases, to enable individuals and communities to prevent and control communicable and noncommunicable disease and improve their health.

Key informants from the Ministry of Health and Social Services highlighted the importance of placing greater emphasis on NCDs and mental health, noting that these areas have gained increased relevance since the development of CCS III. They also suggested that WHO could play a stronger role in supporting the development, review, and updating of health infrastructure policies, strategic plans, and standards, as part of its mandate for health system strengthening.

3.2 Coherence

Key evaluation question 2. To what extent have WHO interventions and implementation approaches integrated and demonstrated synergies and complementarity with one another as well as with interventions carried out by the Government and other partners in Namibia?

2.1 To what extent are Country Office interventions and implementation approaches integrated and synergized internally, and complementary to government and partners' interventions?

Finding 2. There was a degree of internal coherence of WHO interventions, as they were organized around the four strategic priorities of the CCS III. However, the effort to fully align with GPW13 contributed to a certain level of fragmentation in the implementation of WHO's work in Namibia.

CCS III followed the structure of GPW13 and planned interventions under all outcomes and focus areas. WHO planned 91 interventions over the three biennia, covering 10 strategic priority outcomes and 23 focus areas. The actions CCS III proposed under each focus area were not prioritized. A long unprioritized list gives equal importance to all actions, making it difficult to achieve coherence within the country programme and have impactful interventions.

CCS III, with its comprehensive coverage, generated unrealistic expectations about what WHO could do with the resources at its disposal. Trying to cover a relatively large number of actions or interventions spread WHO financial and human resources thinly. The staff numbers in the Country Office were small and, in some instances, there was only one person implementing an intervention that would require more than one person.

The actions or interventions under CCS III were not informed by an explicit theory of change. This made it difficult to determine how the actions within a focus area contribute to the CCS outcomes. It also made it difficult to determine how the actions in two or more focus areas could create synergies between focus areas and make a more impactful contribution to CCS outcomes. It is understood that CCS III was developed at a time when the theories of change approach to strategy development was not promoted within WHO. The revised Country Cooperation Strategy Guide issued in 2023 *(22)* provides guidance on prioritization and the application of a theory of change in developing country cooperation strategies.

Finding 3. WHO interventions and implementation approaches were well integrated and complementary to the Government's interventions. It synergized its work with development

partners and other UN agencies in Namibia. The new UNSDCF offers a platform to further strengthen the inter-agency cooperation and joint programming.

Namibia is a lower middle-income country. WHO's strategy appropriately focused on 'upstream' support in the form of providing access to technical expertise and advice, delivering guidance on WHO normative frameworks, and supporting policy and strategy formulation and reviews. The training WHO provides to the public health sector is about the tools and approaches advocated by WHO to strengthen the capacities that already exist in Namibia. In the case of consultative processes, the Government takes the lead, with WHO providing technical expertise and serving as the custodian of global norms and standards for health. Government partners observed that WHO's presence lends credibility to the Government's agenda to improve the standards and performance of the health sector.

While WHO's emphasis is on upstream work, it also supported 'downstream' interventions, such as testing new approaches and quality standards, that the Government can scale up if successful. Downstream work has also been necessary for health emergencies and outbreaks, and for programmes such as the Expanded Programme on Immunization.

WHO provides modest financial support for activities such as training workshops, the appointment of consultants to provide technical/professional services, and information, education and communication (IEC) materials. Most government partners understand WHO's role as a technical partner and not a donor in the same way as bilateral development partners in Namibia. Nevertheless, they view WHO as an important ally in supporting the Government's resource mobilization efforts.

WHO was instrumental in establishing the Health Development Partners Forum in 2011. The aim of the forum was to enable development partners in the health sector to coordinate their support to Namibia, to make better use of development resources and avoid duplication. UN agencies in Namibia and development partners including United States Government agencies met monthly. WHO utilized the forum to coordinate development partner inputs to the National Health Strategic Plan. The forum also served as a mechanism for coordinating action during the COVID-19 pandemic.

Members of the forum commented positively on the leadership WHO provided to the forum. Bilateral partners saw the forum as an opportunity to meet all UN agencies working in the health sector and to obtain a comprehensive view of what the UN in Namibia was doing in the health sector. For the UN agencies, the forum provided an opportunity to exchange information with other forum members and to keep abreast of what was happening. The Ministry of Health and Social Services and other government ministries are not members of the forum but are invited to make presentations on their programmes and priorities. There were suggestions from the members of the forum that the structure could be expanded into a Sector-Wide Approach (SWAp) that is inclusive of government and other stakeholders in the health sector. Another suggestion was that the forum should move beyond information sharing to strategizing on coordinating more effectively amongst themselves and make it easier for the Government to work with development partners.

UN agencies in Namibia commended WHO's willingness for joint action. WHO collaborated with the United Nations Population Fund (UNFPA) in several areas including SRH, maternal health, the SRH-HIV integration joint programme, comprehensive abortion care, and strengthening health services for adolescents. WHO collaborated with other UN agencies including UNFPA, on gender-based violence

and supported customization of clinical guidelines and training of health care providers. WHO collaborated with UNAIDS, the World Food Programme and the United Nations Children's Fund (UNICEF) primarily on issues pertaining to food security, nutrition, and HIV. There was no substantial collaboration with the Food and Agriculture Organization of the United Nations, although FOA identified One Health as an opportunity for collaboration.

The review of UNPAF 2019–2023 found insufficient joint programming and joint action among UN agencies, except during emergencies such as the COVID-19 pandemic, and that the UNPAF pillars were fragmented by too many activities under each pillars *(21)*. External stakeholders interviewed commented on overlaps between agencies and that from the outside, the division of labour among agencies is not always clear. The Namibia United Nations Sustainable Development Cooperation Framework (UNSDCF) 2025–2029 launched in February 2025, presents an opportunity for WHO and other UN agencies to deepen inter-agency collaboration and strengthen joint programming.

2.2 How has WHO harnessed its comparative advantage, particularly in its role as a convening and coordinating partner and health leader, to deliver on its mandate?

Finding 4. WHO made good use of its comparative advantage as the leader on health issues within the UN system in Namibia, and among development partners. It provided technical leadership during the COVID-19 pandemic, deploying its scientific knowledge to advise the country, and used its convening power to support the Government's efforts to coordinate the national response to the pandemic. WHO was seen by the Government as a trusted partner that adds value to government work in the health sector. WHO ably coordinated the UN health portfolio in Namibia.

Government partners, development partners, UN agencies and other stakeholders see WHO as the leader on health issues within the UN system. WHO's leadership was demonstrated during the COVID-19 pandemic, for example, when it supported the establishment of the National Public Health Emergency Operations Centre to mobilize resources and technical support for the Ministry of Health and Social Services to manage the pandemic effectively. (See question 3.2 for more details on WHO's support to the COVID-19 response.) With its scientific and technical knowledge of COVID-19, WHO guided important government decisions on containment (restricted movement of people) and the content of IEC material, vaccines and vaccination roll-out. Key informants interviewed across stakeholder categories were unanimous about WHO's leadership.

Beyond COVID-19, WHO had high credibility with government partners for its policy and technical expertise in the health sector, and as the global custodian of health norms and standards. WHO has been able to use this credibility to influence Namibia's health policies and strategies. Government partners interviewed were unequivocal about the importance of WHO's presence and its policy and technical inputs to health policies, strategies, programmes, and interventions. According to these key informants, WHO contributions gave the Government confidence that they were following good or best practices, norms and standards, and lent legitimacy to Government efforts.

UN agencies in Namibia expressed positive views on WHO's leadership on health issues and pointed to the strong technical leadership WHO provided during the COVID-19 pandemic. WHO chaired the health pillar under the social transformation component of UNPAF 2019–2023. Through the health

pillar, WHO convened government partners and UN agencies on the UNPAF health priorities. WHO also convened the health pillar to coordinate a UN response or inputs to government policies, strategies and programmes. WHO chaired the Programme Management Team, which reports to the United Nations Country Team, and is seen to be effective in this role by other UN agencies, and an active contributor in the United Nations Country Team.

WHO has used its convening power to coordinate development partners through the Health Development Partners Forum. This convening was especially prominent during the COVID-19 pandemic when development partners needed to coordinate their support to the Namibia COVID-19 response. Although the forum currently is primarily an information sharing platform, WHO has used the forum to coordinate inputs from development partners to the National Health Strategic Framework.

3.3 Effectiveness

Key evaluation question 3. To what extent were WHO results (including contributions at the outcome and system level) achieved or are likely to be achieved and what factors influenced (or did not influence) their achievement?

This section of the report discusses WHO's achievements for each of the Strategic Priorities of the CCS III. It includes an assessment of the status of CCS III indicators and WHO's contribution to the CCS III outcomes. Changes at the outcome level cannot be attributed solely to WHO, as the Government of Namibia plays the lead role in financing and implementation, with development partners and WHO contributing to the achievement of results in the health sector.

3.1 What were WHO's key achievements during the period of the CCS? What factors explain the attainment (or lack thereof) of planned CCS objectives? What challenges were faced in implementing the current CCS?

3.3.1 Strategic Priority 1: Advancing UHC

Table 5 shows the progress towards the outcome indicators targets for Strategic Priority 1. The outcomes for Strategic Priority 1 are as follows:

- Outcome 1.1: Improved access to essential quality health services.
- Outcome 1.2: Reduced number of people suffering from financial hardship.
- Outcome 1.3: Improved availability of essential medicines, vaccines, diagnostics and devices for PHC.

Table 5: Strategic Priority 1: Progress towards indicator targets

Indicators	CCS III Baseline	CCS III Target	Progress: actual value (year)	Performance
Human resources for health per 1000 population	3.6	4.45	7.3 (2022)[a]	
Maternal mortality ratio per 100 000 live births	265	200	139 (2023)[b]	
Neonatal mortality rate per 1000 live births	39	20	24.1 (2023)[c]	

Percentage of women of reproductive age (15–49) who have their need for family planning satisfied with modern methods	—	90%	—[d]	—
Administrative coverage of measles-containing vaccine, 1st dose (%)	79%	90%	91% (2022)[e]	
Malaria deaths	120	50	32 (2023)[f]	
New HIV infections per 1000	4.3	0.9	2.2 (2023)[g]	
Treatment coverage of rifampicin-resistant TB	60%	71%	99.7% (2023)[h]	
Premature NCD-related mortality (deaths due to NCDs among people aged below 70 years, as a percentage of NCD deaths among all ages*)*	43%	35%	54.1% (2019)[i]	
Percent of people suffering financial hardship in accessing health services (spending >10% of household total income on health)	<1%	<1%	—j	—

Key	Achieved		Progress		No Progress	

[a] Source: Asamani JA, Bediakon KSB, Boniol M, et al. *(23)*.
[b] Source: *Trends in maternal mortality estimates 2000 to 2023* *(24)*.
[c] Source: UN Inter-agency Group for Child Mortality Estimation *(25)*.
[d] No data was available for 2018–2024. In 2013, 80.4% of women had their family planning needs satisfied with a modern method *(26)*.
[e] The Global Health Observatory listed a 2018 measles vaccine coverage of 82% *(27)*.
[f] WHO listed 58 malaria deaths in 2018 *(28)*.
[g] Source: UNAIDS *(29)*.
[h] Source: WHO Tuberculosis data *(30)*.
[i] The Global Health Observatory placed premature NCD-related mortality at 53% *(31)*.
[j] No data was available for the CCSII period. In 2009, the percentage of people suffering financial hardship in accessing health services was 1.22% (urban: 1.97%; rural: 0.75%0. In 2015 this rose to 1.52% (urban: 2.04%; rural: 0.75%) *(32)*.

Outcome 1.1: Improved access to quality essential health services

Finding 5. WHO contributed to strengthening Namibia's health system through its support to the Ministry of Health and Social Services to address gaps in the health sector regulatory frameworks, the development and roll-out of quality standards for delivery of health services, and the development of a national strategic plan to address human resources challenges in Namibia's health sector. The roll-out of quality standards was a key achievement for WHO and the Ministry of Health and Social Services in the CCS III period. Although the CCS III target for 4.45 human resources per 1 000 population was exceeded, the distribution of human resources remains a challenge. There was also an unfinished agenda on health-related legislation.

Policy and legislation. WHO supported the health sector performance review, which informed the development of a new National Health Policy Framework 2023–2033. This policy framework was developed in the post-COVID-19 pandemic era and provides a roadmap for accelerating progress in achieving good health and well-being for all Namibians beyond 2030. The policy was not yet adopted by the end of the CCS III period and will likely be adopted by the Government in 2025 *(33)*. WHO provided technical assistance to review the 2014 Namibian Essential Health Care Package and develop

a new National Essential Health Care Package (34). It should be noted that the Cabinet approved the National Policy on Universal Health Coverage in February 2025 (35).[3]

To strengthen the regulation of medicines, WHO enhanced the capacities of the Namibia Medicines Regulatory Council to register medical products efficiently and develop tools, standard operating procedures, and guidelines for internal audit of compliance with ISO 17025 standards (34). There are still gaps in Namibia's health legislative framework. Review and revision of the Blood Transfusion Act of 1962 and the Namibian Medicines and Related Substances Control Act 13 of 2003 were disrupted by the COVID-19 pandemic and were not finalized by the end of the CCS III period.

Quality standards. WHO's support in quality management contributed to the completion of three major documents to guide Namibia in improving the quality of its health services, so that Namibians can access quality health services in urban areas as well as in remote rural areas of the country. WHO led the development of several foundational documents: the National Quality Management Policy 2021/2022–2025 /2026, the National Quality Management Strategic Plan 2021–2026, National Infection Prevention and Control 2023/2024–2026/2027, and the National Surgical, Obstetric and Anaesthetic Plan 2023/204–2026/2027. Additional documents developed include National Infection Prevention and Control Guidelines, National Operation Theatre Guidelines, National Central Sterile Service Department Guidelines, National Clinical and Death Audit Guidelines and National Standard Operating Procedures for Patient/Client Experience and Satisfaction Assessment. WHO also provided support in drafting the National Quality of Care Monitoring and Evaluation Framework. This framework included indicators such as the availability of life support equipment, emergency surgery facilities, and reduction in waiting times at outpatient departments, which are to be integrated into the Health Management Information System upon finalization. Furthermore, to ensure standardized, ethical, and patient-centred care, WHO led the drafting of the National Informed Consent Guidelines, which were in the finalization phase at the time of the evaluation.

The Ministry of Health and Social Services implemented the national health facility quality standards in 10 hospitals and nine PHC facilities to improve the quality of care and patient safety across all levels of service delivery (see Box 1). The implementation of health care facility quality standards provides a means to measure the quality of health services, which, according to the Ministry, has shown improvement. The Ministry credited WHO with assisting in preparing the foundation for quality management through supporting development of guidelines, knowledge and skills. Emerging evidence suggests these efforts are beginning to yield results. For example, a recent study assessing the implementation of WHO/UNICEF/UNFPA maternal and newborn quality-of-care standards in an intermediate hospital in northeast Namibia found foundational systems in place but identified gaps in provider–client communication and information sharing (36). The study emphasized that improved communication skills could significantly reduce neonatal deaths, reinforcing the value of WHO-supported quality improvement efforts. Additionally, during a visit to Opuwo District Hospital, the evaluation team observed the application of quality standards in practice, with staff citing WHO training and support as contributing to tangible improvements in service delivery.

[3] It is probable that WHO played a catalytical role in the policy. As the result (adoption) falls outside the CCS III period, WHO's role and contribution to policy will be covered in the next biennium report and CCS IV evaluation.

Box 1: Implementing quality standards in health facilities

The Quality Standards intervention was designed and implemented as an integrated intervention. The National Quality Management Policy and Strategic Plan provided the foundation for the intervention and a roadmap for implementation.

The technical guidelines and standard operating procedures operationalize the National Quality Management Policy. Each guideline has a training curriculum or component to enable staff in health facilities to apply the guidelines correctly.

The National Quality of Care monitoring and evaluation framework is an important component of the intervention as it will enable the Ministry of Health and Social Services at national, district and facilities level to track improvements in the quality of health service delivery.

Collaboration and partnership are critical ingredients for success. WHO worked in close partnership with the Quality Assurance Division of the Ministry of Health and Social Services in designing the intervention. Working with other partners, such as the Council for Health Service Accreditation of Southern Africa, has been essential to support the rolling out of quality standards in health facilities.

Health facilities participating in the intervention receive a comprehensive package of support that includes baseline assessments, training in quality standards methodology, coaching support, feedback to the facility management, support to address quality assurance gaps, and follow-up assessments. Opportunities are also provided to share and learn from experience of other health facilities implementing quality improvements.

National health workforce. WHO's support enabled the Government to conduct a situational analysis on human resources for health in Namibia and the subsequent development of the National Human Resources for Health Strategic Plan 2020–2030 *(37)*. In addition, WHO built Namibia's National Health Workforce Accounts capacity through training *(34)*. Several key informants identified the lack of sufficient and skilled human resources as a major and ongoing challenge in Namibia's health sector, and identified the need for more support in this area.

Finding 6. WHO contributed to measurable improvements in reproductive, maternal, newborn and child health (RMNCH) over the CCS III period, which saw maternal mortality reduced to 139 per 100 000 live births by 2023, exceeding the CCS target of 200. Good progress was made in reducing neonatal mortality from the CCS III baseline of 39 per 1000 live births to 24.1 in 2023, even though the CCS target of 20 was not achieved. These results were achieved through WHO's technical and financial support that enabled the Ministry of Health and Social Services to review existing guidelines and develop new guidelines for RMNCH and enhance the capacities of health workers to provide quality services in RMNCH.

WHO supported the Ministry of Health and Social Services in a wide range of RMNCH, adolescent health, and nutrition interventions, which included technical support on reviews and guidelines,

advocacy, and training and capacity building. WHO provided support for updating/development of RMNCH and adolescent health strategy, the National Family Planning Guideline, the Namibian Family Planning Medical Eligibility Criteria Wheel, a family planning counselling job aid, and the 2020 ANC guidelines for a Positive Pregnancy Experience and ANC training package *(34, 38, 39)*. WHO also supported the Comprehensive Post-Abortion Care Guidelines and the revision of the national guidelines for the review and response to maternal death, near misses, still births and neonatal death . The indicators for neonatal mortality and maternal mortality are moving in the right direction, and the CCS III target for reducing maternal mortality was achieved.

WHO's support for the development of the National Roadmap for Path to Elimination of MTCT [mother-to-child transmission] of HIV and Congenital Syphilis (2019–2023), hepatitis B virus elimination, and the certification of Namibia's progress towards these contributed to Namibia's progress being certified silver for hepatitis B and Bronze for HIV *(34, 40)*.

WHO provided technical and financial support to the Ministry of Health and Social Services to review and update guidelines and deliver advocacy and capacity building in immunization during the period under review. This included finalizing the National Policy on Adverse Events Following Immunization and the National Plan for Introducing the Human Papillomavirus (HPV) Vaccine, and training 37 newly recruited immunization officers and 414 health care workers in collaboration with other UN agencies. WHO supported the Ministry of Health and Social Services to ensure 309 916 children received measles and rubella vaccines, 20 934 people aged 18 and above received COVID-19 vaccines, and 282 197 children were treated with vitamin A supplements *(34)*.

WHO enhanced the capacities of health workers to improve the quality of services provided to pregnant women, mothers and newborns. This included training 200 health workers in antenatal care for a positive pregnancy experience in all 14 regions of Namibia; training 69 nurses in respectful maternity care; training health care workers on trained on Comprehensive Post Abortion Care to improve access to quality post-abortion care in facilities; and providing preservice Emergency Obstetric and Newborn Care training to 65 University of Namibia (UNAM) final year midwifery students *(38)*. In addition, WHO supported the completion and operationalization of two Maternity Waiting Homes in Opuwo and Gobabis *(34, 38, 39)*.

Finding 7. WHO contributed to expansion in the coverage of immunization through its financial and technical support to the Ministry of Health and Social Services to review and update guidelines, deliver advocacy, and build capacities of health workers in immunization. This support contributed to progress in the coverage of measles-containing vaccine from 79% in the CCS III baseline to 91% in 2022, which was above the 90% target for CCS III. WHO support helped to ensure that children received measles and rubella (MR) vaccines and treatment of vitamin A deficiency.

WHO provided technical and financial support to the Ministry of Health and Social Services to review and update guidelines and provide advocacy and capacity building in immunization during the period under review. This included finalizing the National Policy on Adverse Events Following Immunization and the National Plan for Introducing the HPV vaccine. In collaboration with other UN agencies, WHO supported the training of 37 newly recruited immunization officers on immunization practices and 414

health care workers on the use of online vaccination supplies stock management, enabling them to manage vaccine stock more efficiently. During the 2022–2023 biennium, WHO ensured that 309 916 children received measles and rubella vaccines, and 282 197 children were treated with vitamin A supplements *(34)*.

The Ministry of Health and Social Services confirmed the extensive support received and especially valued the scientific advice from WHO on vaccines for COVID-19, Mpox, and HPV. The Ministry also indicated that the drafting of the HPV vaccine plan was at an advanced stage and likely to be approved in 2025. The district hospital in Opuwo confirmed the training received for immunization and vaccine storage, enabling them to do outreach work for immunization, but noted that immunization coverage in the region remained mode due to the migratory lifestyle of part of the population.

Finding 8. WHO helped strengthen Namibia's prevention and response to HIV, TB and malaria. The Organization's support to Namibia to review and update its strategies and plans for malaria contributed to a reduction in malaria deaths from the CCS III baseline of 120 deaths to 32 deaths by 2023, exceeding the CCS target of 50 deaths. WHO's support for reviewing and updating the TB strategic plan and technical guidelines contributed to improvement in the treatment coverage of rifampicin-resistant TB treatment from 60% CCS III baseline to 99.7% by 2023. WHO, in collaboration with other UN agencies, helped strengthen Namibia's strategic framework and guidelines for HIV and AIDS. There was progress in reducing the rate of new infections from the 4.3 per 1000 at baseline to 2.2 per 1000 in 2023, though the target of 0.9 was not achieved.

HIV. In the period under review, WHO supported Namibia to conduct end-term reviews of the National Strategic Framework for HIV/AIDS, 2017/18–2021/22 and the National Voluntary Male Medical Circumcision Strategic Plan, and to develop a costed national strategic framework for the HIV/AIDS response and a costed national strategic plan for voluntary male medical circumcision for the 2023–2024 through 2027–2028 period *(34)*. The new strategic plans provide the Government and stakeholders with clear direction for working towards ending the HIV pandemic and the costed plans supported the mobilization of resources from the Global Fund to fight AIDS, Tuberculosis and Malaria. Other support included reviewing and updating guidelines on ART, guidelines for management of sexually transmitted infections, and standard operating procedures for pre-exposure prophylaxis to improve the provision of these services.[4]

Tuberculosis*.* WHO contributed to strengthening the Government's efforts to improve the quality, coverage and access to TB services through development of a costed national strategic plan for TB and leprosy for 2023–2024 through 2027–2028, following a review of the previous strategic plan, and by reviewing and updating the TB infection prevention and control guidelines. With WHO support, the Ministry of Health and Social Services integrated the TB monitoring and evaluation systems into the District health management information system, overhauling its TB tracker system, and adding new modules to capture individual leprosy cases and adverse drug reactions within the Namibian health

[4] The withdrawal of United States funding, which occurred outside the evaluation period, may reverse the gains made in Namibia's HIV and AIDS response. See UNAIDS Impact of US funding cuts on Global AIDS Response: Namibia.

care system *(34, 38)*. TB incidence declined during the CCS period from 524 cases per 100 000 to 468 cases per 100 000, but remains higher than the incidence for the Africa region of 206 cases per 100 000 *(41)*.

Malaria*.* WHO provided technical support to the Ministry of Health and Social Services to review and update its strategies and plans for malaria, including the National Integrated Vector Management Strategy, Insecticide Resistance Monitoring Plan, Malaria Communication and Advocacy Strategy 2020–2025, and the National Malaria Elimination Strategic Plan 2023–2027. A significant result was the use of the strategic plan to secure US$ 3.093 million from the Global Fund for malaria elimination *(34)*. WHO also supported the review and update of the Malaria Case Management Guidelines and training packages and the National Malaria Surveillance Guidelines, and the subnational assessment of malaria elimination readiness in six low malaria burden districts. WHO's collaboration with the Ministry of Health and Social Services to implement the three-year AFRO (African Regional Office) II Malaria Control Larviciding Demonstration Project in five malaria-prone districts since 2019 showed positive results: Anopheles mosquito larvae density was reduced by 76%, and malaria cases by 42% in 2019–2020, and 87% in 2021–2022 *(34)*. The number of malaria deaths continued to decline over the period of CCS III and the indicator target was achieved.

Finding 9. WHO contributed to the management of schistosomiasis and other NTDs in Namibia over the CCS III period through its technical support to strengthen the capacities of health care workers and professionals in surveillance and case management, and the development and dissemination of IEC materials. The number of people requiring interventions against NTDs increased slightly from 383 000 in 2015 to 388 000 in 2023, and although the number remained below the 2014 peak of 1 million, the numbers have plateaued since 2015 (41)**. WHO also helped Namibia strengthen its capacity for surveillance and reporting on anti-microbial resistance (AMR).**

During the 2022–2023 biennium, WHO supported strengthening the capacities of 100 health care workers (programme managers, nurses, ophthalmic technical officers, data recorders, community health workers, and partners) in the prevention, control, and elimination of NTDs; 330 clinicians and nurses in case management and surveillance of scabies; and 60 personnel (clinicians, surveillance officers, environmental health practitioners, and stakeholders) in NTDs. WHO also supported the development and dissemination of leaflets and mass media communication on preventing and controlling Scabies, Taeniasis, and Schistosomiasis. During the 2018–2019 biennium, WHO supported the provision of deworming medication for Schistosomiasis and soil-transmitted helminths to over 158 600 school children in six regions where they are endemic (Zambezi, Kavango East, Kavango West, Ohangwena, Omusati, and Otjozondjupa). The deworming programme was discontinued due to concern about side effects and the results of a baseline survey conducted by the Ministry of Health and Social Services in August 2024 is expected to inform how to proceed with deworming in the future.

WHO provided technical support for the development and costing of the Namibia Neglected Tropical Disease Master Plan 2023–2027, the establishment of a National NTD Multisectoral Technical Working Group, and the integration of NTDs in the Third National Integrated Disease Surveillance and Response

Guideline. The NTD Master Plan was still awaiting the endorsement of the Namibian Government at the end of 2024.

Other technical support by WHO included a mapping survey of NTDs in the high-risk regions of Kavango West, Ohangwena, Omusati and Oshikoto; an integrated mapping survey of trachoma, scabies, Guinea worm disease and other NTDs in the Kunene and Zambezi regions; and support for cross-border collaboration on Guinea worm disease surveillance. The development of the Trachoma Elimination Dossier with the support of WHO will enable WHO to validate claims of eliminating trachoma as a public health problem *(42)*.

Anti-microbial resistance. WHO built staff capacity through training on the Global antimicrobial resistance and use surveillance system (GLASS) *(43)* and the use of WHONET *(44)*, which enabled AMR surveillance and reporting to GLASS. The system started with surveillance of AMR in bacteria causing common human infections and has expanded its scope to include surveillance of antimicrobial consumption, invasive fungal infections, and a One Health surveillance model relevant to human health. In addition, WHO provided technical assistance to Namibia in reporting its annual Tracking AMR Country Self-Assessment Survey *(45)*. WHO support enabled Namibia to strengthen multisectoral collaboration through the Multisectoral Committee on AMR and the AMR Technical Working Group. WHO and its partners the Food and Agriculture Organization of the United Nations, the United Nations Environmental Programme, and UNAM supported the development of the Tripartite One Health National Strategy 2024–2028,[5] through which AMR interventions will be implemented in the next CCS period.

Finding 10. WHO support enabled the Ministry of Health and Social Services to strengthen its plans and staff capacities for the prevention, treatment and care of NCDs. However, Namibia has not seen a reduction in premature NCD-related mortality during the CCS III period, suggesting more attention is needed by the Government and its development partners to address NCDs.

WHO supported the Ministry of Health and Social Services to review and update the National Cervical Cancer Elimination Strategic Plan and the National Package of Essential NCD Interventions (PEN), and to procure equipment needed to implement PEN. The Organization also supported the national NCDs programme to print and disseminate 2000 copies of the National Multisectoral Strategic Plan for Prevention and Control of Noncommunicable Diseases (NCDs) in Namibia 2017/18–2021/22. WHO supported adapting the PEN training package and training 72 trainers (doctors and nurses) from different regions on the PEN guideline, who in turn trained health workers in their regions.

The outcome data for premature NCD-related deaths show that persons under the age of 70 years accounted for 54.1% of NCD deaths among all ages in 2019 (the latest data available), an increase from the CCS III baseline of 43%. The WHO Regional Office for Africa's health profile for Namibia highlighted NCDs as a significant health problem in Namibia, with an age-standardized mortality rate across four major NCDs (cardiovascular disease, chronic respiratory disease, cancer and diabetes) of 909 per 100 000 in males and 581 per 100 000 in females in 2021 *(46)*. The interviews with government officials and other stakeholders identified NCDs as an issue to which the Government and its

[5] The Tripartite One Health Strategy 2024–2028 was launched in June 2024.

development partners should give greater priority. Prevention plays an important role in reducing NCDs, and as discussed under Strategic Priority 3, the health promotion agenda was not adequately resourced during the CCS III period.

Outcome 1.2: Reduced number of people suffering financial hardship

Finding 11. The evaluation was unable to determine if there was any reduction in the proportion of the population experiencing financial hardship because of health costs, as no data was available. Though falling outside the CCS III period, the Cabinet approved the National Policy on Universal Health Coverage in February 2025 that has implications for the next CCS.

The CCS III target was to keep the population spending more than 10% of the total household income on health care below 1%, and the actual value in 2015 was 1.52% (urban: 2.04%, rural: 0.75%) *(14)*. Between 2009 and 2015, the total population with household spending on health greater than 10% of total household income remained above 1% for both urban and rural populations nationally. The lack of relevant information on the indicator for the evaluation period (2018–2024) makes it difficult to ascertain whether the indicator may have improved or worsened.

The Ministry of Health and Social Services and the Social Security Commission established the Universal Health Coverage Advisory Committee of Namibia (UHCAN) to guide the Ministry of Health and Social Services in the development of sustainable systems and policies for achieving UHC in Namibia. In collaboration with other UN agencies and US agencies, WHO supported the Ministry of Health and Social Services to institutionalize national health accounts for tracking health expenditures from sources to final users; to produce and disseminate the National Health Account Report (2017/2018) to guide health financing decision-making; to develop a health financing position paper; and to hold national policy dialogue on UHC with the executive directors of line ministries and the Ministry of Health and Social Services leadership to raise awareness of the importance and implications of achieving Health for All.

In February 2025, Namibia's Government Cabinet approved the National Policy on Universal Health Coverage, with the main objective of ensuring that all citizens country-wide have access to the health care they need without financial hardship *(47)*. The Cabinet further directed the Ministries of Works and Transport (Convener), Health and Social Services, and Finance and Public Enterprises, and the National Planning Commission to develop implementation and funding modalities for this policy and submit a report to Cabinet for endorsement. The Inter-Ministerial Committee may co-opt any other relevant stakeholders. The Ministry of Health and Social Services has proposed to raise funds through dedicated levies on alcohol and tobacco, which would be placed in the National Health Equity Fund to finance UHC policy implementation *(48)*. Key informants underscored the need for WHO to get more involved over the next CCS period in the ongoing discussions on sustainable health financing to implement the Namibia UHC policy amidst shrinking external funding for health.

Outcome 1.3 Improved availability of essential medicines, vaccines, diagnostics and devices for PHC

Finding 12. WHO was effective in increasing access to medical products, supplies and equipment in response to the COVID-19 pandemic. WHO also supported the Ministry of Health and Social Services in the development of standards for procurement and supply of essential medicines, vaccines and medical equipment. Health care technology has been changing rapidly, and existing policies need to be updated to reflect these changes.

Essential medicines. WHO provided critical support to the Government during the COVID-19 pandemic, using its health procurement expertise and access to the UN procurement platform to facilitate the procurement of essential medical products, supplies and equipment. The Organization's contribution to the COVID-19 response is expanded on in evaluation question 3.2. In addition, WHO support enabled the Ministry of Health and Social Services to develop and disseminate the National Essential Medicines List and the Standard Treatment Guidelines, and to produce the Clinical Supplies Catalogue.

WHO, along with other UN agencies, supported the implementation of the revised National Medicines Policy launched in 2022. The revised policy aimed to strengthen pharmaceutical services, improve medicine accessibility, and enhance supply chain management. It updates the original policy of 24 years and covers new, emerging and re-emerging diseases and medicines, the financing and pricing of medicines, global trade in pharmaceuticals, human capacity development, research and development, and technical cooperation and assistance *(49)*.

Essential equipment. With WHO support, the Ministry of Health and Social Services developed the PHC Facilities Standards, first edition 2021 and the Hospital Quality Standards 2021 discussed under Health Systems Strengthening. Implementation of the quality standards is yielding results as mentioned previously. The cost of equipment was a challenge, and WHO facilitated support from donors for ultrasound machines to 16 hard-to-reach and high-volume PHC facilities in all 14 regions of Namibia.

3.3.2 Strategic Priority 2: Addressing health emergencies

Table 6 summarizes the achievements against the CCS targets for Strategic Priority 2. The outcomes for Strategic Priority 2 are as follows:

- Outcome 2.1: Country health emergency preparedness strengthened
- Outcome 2.2: Emergence of high-threat infectious hazards prevented
- Outcome 2.3: Health emergencies are rapidly detected and responded to.

Table 6: Strategic Priority 2: Progress towards indicator targets[a]

Indicators	CCS III Baseline	CCS III Target	Progress: actual value (year)	Performance
Proportion of core surveillance and response capacity requirements for IHR met	<10%	50% increase	66.3% (2023)	Achieved (green)
Proportion of suspected outbreaks investigated in time and contained	67%	100%	100% (2023)	Achieved (green)

Key: Achieved (green) | Progress (yellow) | No Progress (red)

[a] Source: WHO Country Office in Namibia Biennial Reports 2020–2021 and 2022–2023 (34, 38).

Finding 13. WHO contributed to strengthening Namibia's emergency preparedness and response by supporting the development of action plans and early warning systems, and the establishment and capacity building of the National Emergency Management Team. By 2023, Namibia was able to meet 66.3% of the IHR core surveillance and response capacity requirements, exceeding the CCS III target. Namibia also increased its the effectiveness in investigating and containing suspected outbreaks, notably the hepatitis E virus, which saw the number of deaths reduced to zero in 2021.

Outcome 2.1 Country health emergency preparedness prepared

With WHO support, the Ministry of Health and Social Services developed and launched its costed National Action Plan for Health Security 2020–2025 to guide Namibia's progress in achieving core IHR capacities. WHO supported the development of the National Multi-Hazard Emergency Preparedness and Response Plan, launched in March 2025 to replace the 2013 plan. WHO support included the introduction of a public emergency operations centre handbook, a digital learning platform that will enable virtual training of health workers, and the distribution of electronic tablets to community health workers *(50)*. A national emergency medical team was established, and WHO supported induction training for 50 EMT staff to enable them to provide immediate medical care during large scale emergencies.

WHO committed US$ 2.8 million through a memorandum of agreement with the Ministry of Health and Social Services to (a) promote resilience of systems in emergencies to prevent, predict, timeously detect, and effectively respond; (b) transform African surveillance systems to coordinate and strengthen integrated surveillance systems and actions to prevent/respond outbreaks; and (c) strengthen and utilize response groups for emergencies to fast-track capacity building to onboard 3000 African Health Volunteer Corps ready for deployment within 24 hours. Namibia has developed an action plan to implement parts (b) and (c).

Building on the experiences and lessons from the COVID-19 pandemic, WHO supported the Ministry of Health and Social Services to strengthen Namibia's risk communication systems. In partnership with the United States Centers for Disease Control and Prevention, WHO supported the Ministry of Health and Social Services to train 33 regional risk communication and community engagement (RCCE) coordinators and regional RCCE pillar leads to strengthen risk communication systems at the regional and district levels. The training enabled regional teams to revise their action plans to strengthen regional and district RCCE interventions *(51)*. WHO support enabled the Ministry of Health and Social Services to develop a National Strategy on RCCE, which was awaiting approval, and integrate RCCE into the draft health promotion policy *(34)*.

Outcome 2.2: Emergence of high-threat infectious hazards prevented

Surveillance capacity strengthened. WHO helped strengthen Namibia's surveillance capacity through the review and revision of Namibia's Integrated Disease Surveillance and Response Guidelines, second edition in 2021, by training 182 health workers on the guidelines, and by providing financial support to roll out the guidelines to all 36 health districts of Namibia *(52)*. The Integrated Disease Surveillance and Response Guidelines, third edition was finalized and launched in June 2023 with WHO support.

Response to outbreaks. WHO supported Namibia to successfully combat the hepatitis E virus outbreak, which had spread to 13 of 14 regions between 2017 and 2022, by playing a strong convening and coordinating role in mobilizing other UN agencies, development partners, regional and local authorities, and civil society organizations to rally behind the Government to control the outbreak. In addition, WHO supported the development of a costed multisectoral response plan, the conduct of a rapid assessment of the hepatitis E virus outbreak response and continued integrated hepatitis E support supervision visits to affected regions.

WHO support also strengthened laboratory diagnostic capacities by training and deploying 24 epidemiologists for the hepatitis E virus outbreak response, developing an incident management system, and strengthening the reporting systems at the National Public Health Emergency Operations Centre. Implementation of hepatitis E interventions focused on the five most affected regions in Namibia, using community-level detection mechanisms and treatment for hepatitis E in patients. The support of WHO and its partners contributed to a 97.4% reduction in hepatitis E cases (2775 cases in 2019 to 72 cases in 2021) and a 100% decrease in hepatitis E deaths (23 deaths in 2019 to 0 in 2021) *(53)*.

In addition to providing hepatitis E and COVID-19 response support, WHO and its partners supported Namibia in combating cholera and Crimean-Congo haemorrhagic fever and conducted surveillance of acute flaccid paralysis. WHO's support led to the development of a national multi-hazard emergency preparedness and response plan; a cholera contingency plan to improve prevention, preparedness and timely responses to cholera outbreaks; a national respiratory pathogen pandemic preparedness plan; and Namibia Medical Regulatory Council and ministerial approval in June 2023 for the introduction of the novel oral polio vaccine type-2 *(34)*.

Outcome 2.3: Rapid detection and response to health emergencies

The Government of Namibia and the Robert Koch Institute (a WHO Collaborating Centre) embarked on a twinning project with the long-term goal of establishing a Namibia Institute of Public Health, which will consolidate public health functions at the national and subnational levels and bring together the data and expertise required to coordinate public health efforts across multiple sectors *(54)*. The initiative is part of the Global Health Protection Programme. WHO has played a facilitative role in the partnership and provided technical guidance on aspects such as laboratory systems and surveillance frameworks to align with international standards. The establishment of the Institute is still in progress.

WHO supported the Ministry of Health and Social Services to transition from the ICD nineth revision to the tenth and now the eleventh revisions. ICD-11 was designed to improve morbidity coding and reporting and the handling of medication certification cause of death procedures for the electronic death notification system, among other things. It includes cancer registries, anti-microbial resistance, and coding for traditional medicine conditions *(55)*. Transitioning to ICD-11 requires investment in capacity, information and communication infrastructure, coordination of institutions, and data systems interoperability. WHO supported the Ministry of Health and Social Services to convene stakeholders in government, the private sector, and academic institutions to develop the transition plan in 2023 *(56)*.

3.3.3 Strategic Priority 3: Promoting healthier populations

Table 7 summarizes the achievements against the CCS targets for Strategic Priority 3. The outcomes for Strategic Priority 3 are as follows:

- Outcome 3.1: Determinants of health addressed leaving no one behind
- Outcome 3.2: Reduced risk factors through multisectoral approaches
- Outcome 3.3: Health promotion in all policies and settings.

Table 7: Strategic Priority 3: Progress towards indicator targets

Indicators	CCS III Baseline	CCS III Target	Progress: actual value (year)	Performance
Percentage of stunted children under 5 years	24%	14%	16.8% (2022)[a]	(yellow)
Access to safe drinking water - percentage of households using improved sources of water	Urban: 98.3% Rural: 84%	Urban: 100% Rural: 95%	Urban: 98.0% (2023)[b] Rural: 83.5% (2023)	(red)
Access to safe sanitation: households use improved toilet facilities not shared with other households	Urban: 77% [c] Rural: 28%	Urban 87% Rural 40%	Urban: 50% (2023)[d] Rural: 20% (2023)	(red)
Age-standardized prevalence of tobacco use among men aged 15 years & older.	19%	—	22.1% (2025)[e] 23% (2022)	(red)
Suicide mortality rate (per 100,000 population)	22.1	—	8.6 (2021)[f] 13.5 (2019)[g]	(yellow)
Prevalence of obesity in **women** (35-64 yrs.)	32%	—	16.2% (2019) 15.1% (2016)[h]	(yellow)

Key	Achieved	(green)	Progress	(yellow)	No Progress	(red)

[a] Source: WHO Data *(57)*.
[b] Source: Namibia Statistics Agency *(5)*.
[c] The Global Health Observatory listed access to safe sanitation for 50% of urban households and 19% of rural ones in 2018 *(58)*.
[d] Source: UN Water *(59)*
[e] The Global Health Observatory database did not include data from 2018 *(60)*.
[f] WHO Data gave a 2018 suicide mortality rate of 8.3 per 100 000 *(61)*.
[g] The Global Health Observatory gave a 2018 suicide mortality rate of 13.7 per 100 000, a number that dropped to 13.5 in 2019 GHO *(62)*.
[h] Source: Global nutrition report *(63)*.

Outcome 3.1: Determinants of health addressed leaving no one behind

Finding 14. WHO, in partnership with other UN agencies and civil society organizations, helped to strengthen Namibia's capacity to improve the nutritional status of Namibians through support for the development of nutrition policy and guidelines, the training of health workers on guideline application, and the development and operationalization of nutrition security coordination structures. These interventions plausibly contributed to the reduction in stunting among children under five years from the 24% baseline to 16.8% in 2022, though this remains above the CCS III target of 14%. The prevalence of obesity among women aged 35-64 years also declined from 32% baseline to 16.2% in 2019.

WHO supported a wide range of initiatives aimed at improving the nutritional status of Namibians, especially infants, children and adolescents. These initiatives included working in partnership with civil society organizations in the food and nutrition sector. WHO support enabled the Ministry of Health and Social Services to draft guidelines for the integrated management of acute malnutrition in children aged 0 to 59 months, pregnant and lactating women, finalize baby-friendly hospital initiative guidelines to support breastfeeding within hospitals, and train 100 health workers six regions on management of severe acute malnutrition *(34, 38)*. The Nutrition and Food Security Alliance of Namibia trained 138 Community Health Workers employed by the Ministry of Health and Social Services and civil society organizations to deliver nutrition-related interventions in three regions to reduce illness, preventable deaths, and inequities related to malnutrition. The participants reported

increased knowledge of nutrition, healthy eating practices, and the prevention of malnutrition; the intention to apply the learned knowledge in their personal lives and communities; and boosted confidence in their ability to provide nutrition education to others *(64)*.

WHO supported the Ministry of Health and Social Services to train 1081 Community Health Workers on nutrition task-shifting skills in eight regions, resulting in an increase in vitamin A supplementation coverage from 56% in 2021 to 77% in 2022 *(34, 38)*. Other training interventions included working with the Ministry of Health and Social Services to develop and deploy the Nutrition Assessment, Counselling and Support in-service training curriculum, training health care workers to use the revised WHO standards and guidelines to effectively manage children admitted with severe acute malnutrition in hospitals, and training 326 health care providers in all 14 regions to promote good nutrition; prevent and manage malnutrition through nutrition assessment, counselling, and support; promote breastfeeding; and use inpatient management for severe acute malnutrition *(34)*. WHO as part of the wider UN team, supported the development of the Revised National Food and Nutrition Policy 2021 and its implementation action plan, and the establishment of Namibia's food and nutrition security coordination structures. Stunting of children remains a serious problem in Namibia even though its prevalence is declining.

WHO supported several initiatives in school health, in collaboration with other UN agencies. This included supporting the implementation of the Health Promoting Schools Initiative in 59 schools in two regions, the training of Regional School Health Task Forces on school health and the Health Promoting Schools Initiative, and the health education programmes in schools in all regions. WHO support enabled the completion of the National Policy on Integrated School Health and Safety, which will be presented to the Cabinet in 2025.

Finding 15. WHO partnered with local municipalities and regional councils, UNICEF and the Namibia Red Cross Society to improve access to safe drinking water and safe sanitation for underserved communities in rural areas and in informal settlements, and to promote hygiene in local communities. Namibia has not made discernible progress towards the CCS III targets on water and sanitation.

Environmental health: WHO played a pivotal role in coordinating resources for providing water, sanitation and hygiene services to underserved communities, especially during the hepatitis E outbreak response and the COVID 19 pandemic. Advocacy meetings were held with regional and town councils in Khomas and Erongo regions, which resulted in the supplying of additional safe drinking water in affected communities. Through a partnership with UNICEF and as result of this advocacy work, the communities in informal settlements in the Khomas region were mobilized to construct pit latrines through the Community-led Total Sanitation Initiative. WHO further partnered with the Namibia Red Cross Society on hygiene promotion through community engagement interventions in the Khomas, Erongo, Omusati and Ohangwena regions. The Municipalities of Windhoek and Swakopmund in partnership with WHO also conducted intensive water, sanitation and hygiene-related activities including hygiene promotion through community health workers and health promotion officers, with the distribution of water purification tablets, construction of hand washing

stations (tippy taps) in schools and affected communities, and health education to street vendors and other small business owners housed at different small and medium enterprise parks. WHO supported this initiative with trainings, mentorship and supervision.

Outcome 3.2: Reduced risk factors through multisectoral approaches

Finding 16. WHO strengthened Namibia's capacity to reduce risks to health from tobacco use, excessive alcohol use, and substance abuse. Through the support of WHO and other UN agencies, Namibia established the National Drug Control Commission, strengthened tobacco control measures, and piloted approaches to rehabilitation for alcohol and substance use disorders. Despite these actions, tobacco use among men 15 years and older increased slightly from the 19% CCS baseline to 23% in 2022. WHO also supported multisectoral coordination to strengthen policies for increased physical activity and promote wellness.

Drug control: WHO, in collaboration with other UN agencies, supported the Government to develop the third edition of the Namibia National Drug Master Plan 2020–2025 and establish the National Drug Control Commission to oversee its implementation. The Master Plan adopts a multisectoral approach that addresses social and health issues in addition to law enforcement. The Commission was inaugurated in July 2023.[6]

Alcohol control: WHO supported Ministry of Health and Social Services to implement screening and brief interventions for motivational stages to change alcohol intake patterns in regions with high alcohol consumption and to pilot the outpatient rehabilitation programme for substance use disorders in Kavango East and West as well as the Kharas Regions. In 2023, Kavango East and West regions recorded 104 people screened using the screening and brief intervention tool, and 45 clients stopped drinking alcohol through appropriate interventions *(34)*. These two projects were rolled out to all regions with additional support from the Global Fund. To generate evidence that will inform future policies and interventions, WHO also supported surveys on the prevalence of foetal alcohol spectrum disorders, progress toward attainment of SDG health target 3.5 (prevention and treatment of substance abuse), and the prices and taxation of alcohol products in the African region, as well as the Global Survey on Alcohol and Health.

Tobacco control: To strengthen tobacco control measures in Namibia, WHO supported the Government to train approximately 80 stakeholders from 14 regions on the WHO Framework Convention on Tobacco Control (FCTC), the MPOWER package[7] and the Tobacco Product Control Act 2010. With support of WHO, the Government held two consultations on the Tobacco Product Control Act with clear recommendations for alignment to the FCTC and regulation of new and novel tobacco products. In 2023, with support from the Country Office, the Ministry of Health and Social Services

[6] The evaluation could not find information on activities implemented by the Commission.
[7] MPOWER is a technical package of demand-reduction measures to help countries implement the FCTC and reduce tobacco use.

trained 49 environmental health officers from the Ministry, town council members, social workers, and law enforcement agency staff on the Tobacco Control Act, its regulation, and its alignment with the FCTC. In June 2024, the Government signalled its intention to review the Tobacco Product Control Act 2010 and its regulations and to develop a national strategic plan for tobacco control.

Tobacco cessation is part of the substance use disorder Rehabilitation Programme, and the Tobacco Cessation Guidelines are included in the PEN guidelines. The Ministry of Health and Social Services has conducted awareness campaigns on the risks associated with tobacco use in all regions with different audiences and annually commemorates World No Tobacco Day. Engagement on the Tobacco Product Control Act is conducted annually, targeting local business owners, schools, and community leaders to ensure compliance with smoke-free policies and bans on tobacco advertising, promotion and marketing. Namibia participates periodically in the Global Tobacco Control Report.

Physical activity: With support from WHO, other UN agencies, and GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit), the Ministry of Education, Arts and Culture and the Ministry of Youth and Sport drafted and launched the Integrated Physical Education and School Sports Policy. Through the same multisectoral coordination, the Ministry of Education, Arts and Culture revised the physical education curriculum for grades 1-7. An assessment of infrastructure in government schools for physical activities was conducted to provide a baseline of infrastructure and to inform planning. WHO provided training on the importance of walking and cycling and the use of the Health Equity Assessment Toolkit with the Government, including the Wellness Programme managers/ focal points in government, under the leadership of the Office of the Prime Minister. Leveraging the UN Road Safety Week and Healthy Cities Initiative, WHO further advocated for road infrastructure development and redesign to increase walking and cycling. The Ministry of Health and Social Services and the Ministry of Information and Communication Technology launched a physical activity campaign during COVID-19 through promotional materials posted on different digital platforms.

Outcome 3.3: Health promotion in all policies and settings

Finding 17. WHO support strengthened Namibia's health promotion policy environment and the capacities of health workers to implement health promotion strategies. Notable achievements include the Second National Decade of Action for Road Safety Strategy and inclusion of mental health and suicide in the new Integrated School Health and Safety Policy. Health promotion, however, was under-resourced relative to the other three WHO strategic priorities and some planned interventions could not be fully implemented.

Health promotion. WHO supported the Government to produce the draft Sixth National Health Promotion Policy (2023–2027) and the draft National Strategy for the Implementation of Health in All Policies. These need to be approved by the Government for implementation.[8]

[8] The Country Office informed the evaluation that the draft has been finalized and validated since December 2024 and is with the Ministry of Health and Social Services awaiting approval.

Namibia received support from the WHO Regional Office for Africa to mainstream behavioural insights in public health *(65)*. This entailed providing technical support to the Ministry of Health and Social Services and UNAM health sciences and veterinary medicine to identify priority areas where behavioural insights could improve outcomes, future research, educational curricula and health care strategies. This was followed by a technical workshop on behavioural insights conducted by WHO headquarters for Ministry of Health and Social Services and UNAM teaching staff. WHO headquarters and the Regional Office supported UNAM to develop a curriculum for a postgraduate behavioural insights diploma and a behavioural insights unit in the Master of Public Health and Master of Epidemiology curricula. Prior to this, UNAM teaching staff at the School of Public Health participated in WHO's six-month global intensive training-of-trainers in behavioural insights.

WHO supported the Ministry of Health and Social Services to train and deploy community health workers in health promotion strategies and RCCE in selected urban settlements (Windhoek and Swakopmund) and to host a workshop to develop IEC materials for common diseases. The workshop created an information pool for health content development for common diseases, including definitions, signs and symptoms, complications, transmission routes, prevention measures, risk factors, target audiences, key messages, and communication channels. A social media card for each identified disease was drafted for use by IEC officers and researchers.

RCCE: WHO was central to all health emergencies, and RCCE and social mobilization played a vital role in preparedness and response. The Country Office supported the drafting of communication strategies and action plans as well as the production of communication materials for several outbreaks, including Crimean-Congo haemorrhagic fever, hepatitis E virus, mpox, cholera and COVID-19. With support from WHO, the Ministry of Health and Social Services conducted a knowledge, attitudes and practices study to inform the drafting of a communication strategy to increase demand for and uptake of the COVID-19 vaccine. The results were shared widely and used to disseminate correct information about the public health and social measures to control COVID-19. WHO conducted an introductory training on infodemic management to 30 participants from the regional RCCE committee, including staff of the Ministry of Communication, Information and Technology. Additionally, WHO provided training to community volunteers and community health workers on hepatitis E and COVID-19 to strengthen community engagement. WHO chaired the United Nations Communication Group for COVID-19 and coordinated UN communication support to the Government. WHO and the United States Centers for Disease Control and Prevention supported the training of RCCE officers on RCCE, COVID-19 and cholera.

NCDs. Namibia has a National Multisectoral Strategic Plan for Prevention and Control of Noncommunicable Diseases (NCDs) 2017–2022. WHO supported the review of the strategic plan that will help shape the new strategic plan. The probability of dying from NCDs in Namibia has remained steady between 2010 (26%) and 2019 (23%) and this suggests that interventions in NCDs need to be more effective. Key informants in the Ministry of Health and Social Services expressed the need for greater attention to NCDs, concerned by what they perceive to be an increase in NCDs and insufficient

investment in NCDs and in health promotion to prevent NCDs. Similar concerns were expressed by key informants from WHO headquarters and the Regional Office.

Mental illness, injuries and disability, suicide prevention. WHO is supporting the Government with the development of the Second National Strategy for the Prevention of Suicide 2024–2028. The Ministry of Health and Social Services established a multisectoral committee on suicide prevention, with experts from different ministries and agencies, as well as representatives from the regions. This committee was tasked to develop the second Suicide Prevention and Treatment Strategic Plan 2024–2028, with a clear implementation plan, as well as the Suicide Prevention Community Toolkit, which is adapted from the WHO Suicide Prevention Community Toolkit. WHO contributed to the development of the first National Strategy for Prevention of Suicide 2018/19–2022/23, including a national study on the prevalence of suicide, to inform the national suicide prevention strategy. Between 2017 and 2019, the suicide mortality rate decreased by 0.6 per 100 000 population (0.7 among females and 0.5 among males). Additionally, the 2019 suicide mortality rate for males (14.2) was more than five times that of females (2.2) *(61)*, underscoring the need for research into root causes and the development of male-oriented mental health services.

With support from WHO and other partners, the Ministry of Health and Social Services finalized the adaptation of the Mental Health Gap Action Programme (mhGAP) guidelines for mental, neurological, and substance use disorders. Parallel to this, the Ministry also adapted the Community Toolkit for Mental Health and the Mental Health Gap Action Programme (mhGAP), intending to expand mental health services beyond the PHC setting by highlighting the opportunities that exist within communities to promote mental health, prevent mental health conditions, and expand access to mental health services. This will also help to combat the stigma, discrimination, social exclusion and human rights abuses that affect people with mental health conditions.

The new Integrated School Health and Safety Policy includes mental health and suicide prevention to address concerns about the rates of suicide among young people, and WHO supported the training of regional health taskforce members and health workers in mental health and suicide prevention. WHO supported the Ministry of Health and Social Services to adapt the mhGAP guideline for mental, neurological and substance use disorders, and is currently supporting the finalization of the mental health bill and its regulations. While acknowledging WHO's contribution, key informants in the Ministry of Health and Social Services identified the need for more attention to mental health from the Government, partners, and WHO.

There were achievements in road safety. The Government, with the support of WHO and other partners, developed the Second National Decade of Action for Road Safety Strategy 2021–2030. The Government has also established a multisectoral coordination structure comprising committees for each of the five pillars of the strategy: road safety management, safer roads and mobility, safer vehicles, road safety users, and post-crash response. WHO supported improvements to the quality of road safety data, and according to key informants the technical support from WHO has made a positive difference in data quality.

3.3.4 Strategic Priority 4: Strengthening leadership, governance and enabling functions

Outcome 4.1: Strengthened data and innovation

Finding 18. WHO helped strengthen the data capacities of the Ministry of Health and Social Services and the Namibia National Statistics Agency, enabling these institutions to enhance the health management information system and generate analytical data to inform policies and planning. While there is still scope for reducing the fragmentation of health information in Namibia, WHO support has enabled Namibia to embark on developing its National Health Research Strategic Framework, and work is in progress.

Data and digital health. WHO supported the Ministry of Health and Social Services to finalize and launch the National e-Health Strategy 2021–2025 and to develop and pilot two digital health platform modules (billing and registration). A study reviewing 34 e-Health strategies in the Africa region assessed Namibia's e-Health strategy as strong (along with those of eight other countries) *(66)*. Key informants in the Ministry of Health and Social Services confirmed the technical and financial support received from WHO to improve data management. They indicated that more effort was required to strengthen the health information system in Namibia, paying attention to coordination and integration of the multiple parallel health information systems that lack interoperability. The National e-Health Strategy needs to be reviewed in 2025, and the Ministry of Health and Social Services flagged the need for WHO support on this. The Ministry of Health and Social Services also identified the need to build capacity and address infrastructure constraints to implement the strategy. Poor connectivity in rural areas, continued reliance on paper-based systems in health facilities, and the lack of digital competencies among health care workers are key challenges to implementing the strategy.

WHO supported the Namibia National Statistics Agency in the development of the Namibia Vital Statistics Report: Births, Marriages and Deaths 2018–2021, the Namibia Mortality and Causes of Deaths Report 2018–2021, and the 2020 Namibia Mortality and Causes of Death Statistics report. WHO, in collaboration with UNFPA, UNAIDS, and the United States Agency for International Development, provided financial and technical support to establish national health accounts and the National AIDS Spending Account. This has enabled the Government to improve its estimates of health expenditures.

Research. In 2023, WHO supported and facilitated a national consultative process to develop the National Health Research Strategic Framework, following Ministry of Health and Social Services assessment of the gaps in Namibia's health research, using the WHO Regional Office for Africa's National Health Research Strategy questionnaire. The consultation, under the leadership of the Ministry of Health and Social Services, brought together stakeholders from the National Planning Commission, the National Commission on Research, Science and Technology, academic institutions and development partners. A draft strategic framework was developed and is designed to guide health research priorities and promote evidence-based decision-making for 10 years, with periodic reviews every five years. The framework was not yet completed at the time of the evaluation.

3.2 How effective was WHO's country-level COVID-19 response in supporting national health systems in managing the pandemic? Were there any best practices, innovations, or lessons learned from WHO's interventions in Namibia during the COVID-19 response? How can these insights inform future WHO interventions and specifically strengthen pandemic preparedness and response in Namibia?

Finding 19. WHO was highly effective in leading the UN support for Namibia's response to the COVID-19 pandemic, and valuable lessons were generated to inform future WHO interventions. The pandemic underscored the importance of investing in the PHC system as the frontline of health service delivery and in emergency preparedness.

WHO played a pivotal role in supporting Namibia's response to the COVID-19 pandemic through various initiatives and in collaboration with other UN agencies, development partners and civil society. It provided leadership in establishing the National Public Health Emergency Operation Centre to mobilize resources and technical support for the Ministry of Health and Social Services to manage the pandemic effectively. WHO assisted in the development of the National Deployment and Vaccination Plan for COVID-19, which guided the vaccination rollout across the country and included strategies for reaching vulnerable populations. WHO used its procurement capabilities and assisted the Government to procure medical equipment, personal protection equipment over 1, and 7 million doses of vaccine. During the COVID-19 pandemic 20 934 people aged 18 and above received COVID-19 vaccines.

Over 3000 health providers were trained on various aspects of COVID-19 management, including contact tracing, case investigation, and infection prevention and control. Dissemination of accurate information on COVID-19 was another critical contribution of WHO. This included the distribution of over 1 million copies of IEC materials to educate the public on preventive measures. WHO reprogrammed approximately US$ 3.7 million to support COVID-19 related service delivery and emergency preparedness. Another important contribution was WHO support to strengthen genome sequencing capacity for monitoring and testing the Omicron variant of the virus *(34)*.

Senior government officials, civil society and other UN agencies commended WHO's strong convening, coordinating and technical role during the COVID-19 pandemic response. They attested that WHO competently mobilized UN agencies, development partners, regional and local authorities, and civil society organizations to rally behind the Government to combat the COVID-19 pandemic *(67)*. These positive views were reiterated by key informants during the current evaluation.

The COVID-19 pandemic provided several lessons for WHO in Namibia, and its partners in government.

- The COVID-19 pandemic highlighted the importance of investing in emergency preparedness. At the time of the pandemic, Namibia was operating under the 2013 Multi-Hazard Emergency Preparedness and Response Plan. A new plan was launched in March 2024.
- The COVID-19 pandemic also highlighted the importance of investing in strengthening the PHC system as the frontline of health service delivery. The pandemic saw an increase in the number of health professionals in the public health system. The importance of prioritising investment human resources for the frontline is an important lesson that should be taken forward in the next CCS. The Government recently announced the establishment of over 11 000 new positions in the public health sector.

- Another important lesson from the COVID-19 pandemic is the necessity for effective risk communication systems to ensure that citizens are well informed and are not mislead by rumours and misinformation. WHO in partnership with the United States Centers for Disease Control and Prevention has been supporting the Government to strengthen its risk communication systems following the COVID-19 pandemic.
- The pandemic also spotlighted the importance of coordinated multistakeholder action to respond to large-scale emergencies. Multistakeholder coordination played a key role in Namibia's ability to respond to the pandemic.
- The importance of partnership and collaboration with the private sector is another key lesson from the pandemic. Collaboration and partnerships with the private sector need not be confined to emergencies but can be leveraged to support other vital areas of need in the health sector.

3.3 What has been the added value of WHO regional and headquarters contributions to the achievement of results in Namibia?

Finding 20. The added value of the Regional Office and WHO headquarters was the specialist expertise they provided to Namibia on a range of policy, strategy, and technical matters. The specialist expertise complemented the vital support provided by the Country Office. Namibia benefited from best practices from the global and regional levels. The missions from WHO headquarters and the Regional Office, individually or jointly, provided opportunity for knowledge exchange among the three levels of the Organization.

WHO headquarters and the Regional Office provided mainly technical support to Namibia as well as capacity building. The technical support entailed reviewing and updating policies, strategies, and technical guidelines, and the capacity building was mostly in the form of training in new guidelines. They also provided capacity support (technical and some financial) to enable Namibia to conduct surveys, analyse data, and report and disseminate results. The support covered the CCS strategic priorities. Some missions were conducting jointly by WHO headquarters and the Regional Office, and all missions included the Country Office.

As examples, WHO headquarters and the Regional Office provided support on the following:

- The Neglected Tropical Diseases Master Plan 2023–2027 and multisectoral NTD capacity strengthening
- The National Strategic Plan for Tuberculosis and Leprosy 2023/24–2027/28
- Namibia's prevention of mother-to-child transmission programme
- The National Quality Management Policy 2021/22–2025/26
- Strengthening AMR surveillance, laboratory capacity, infection prevention, and awareness of AMR.
- Data quality review
- Prequalification of pharmaceutical quality control laboratories
- Post-marketing surveillance of anti-TB medicines
- Strengthening the National Rehabilitation Programme
- Analysis of surveys on the national health research system
- The National Multisectoral Strategic Plan for Prevention and Control of Noncommunicable Diseases (NCDs) in Namibia 2017/18–2021/22

- Training in serological techniques and quality assurance of National Institute of Pathology
- Adaption of the Clinical Handbook for the Health Care of Survivors Subjected to Intimate Partner Violence and/or Sexual Violence
- Training on the WHO FCTC
- National capacity for preparedness and response to public health emergencies
- The knowledge, attitudes and practices survey, Understanding the Drivers of Non-adherence Towards COVID-19 Preventive Measures in Namibia
- Standard Operating Procedures for Mental Health in HIV and TB Care (2023)
- HIV and TB Mental Health Tool Kit for Community Health Workers (2023)
- Training in behavioural insight

Key informants from the Government were appreciative of the high quality of technical expertise provided by the Regional Office and WHO headquarters, especially in areas where national capacities were limited or non-existent. The presence of technical experts from the Regional Office and WHO headquarters gave government partners the assurance that Namibia was receiving expert information that the Government could rely on. It also provided an opportunity for government partners to share directly with these two levels the challenges and successes they experienced in advancing progress towards the national priorities for the health sector.

From the review of the biennial reports, the interviews held with units in the Regional Office and WHO headquarters, and back-to-office reports, it was evident that the technical expertise provided by these two levels of the Organization was critical to the achievements discussed in evaluation question 3.1. As it is not efficient to house the full spectrum of technical expertise in the Country Office, the delivery of CCS III must include the two other levels of the Organization. The Country Office, however, plays a critical role as the interlocutor for the Regional Office and WHO headquarters. Requests for assistance come via the Country Office and the latter is best placed to contextualize the requests for assistance. The Country Office plays a critical role in the post-mission period by following up on decisions and actions agreed to during the mission.

3.4 Efficiency

3.4 To what extent is the current human resource complement fit for the level of health system of the country and required technical assistance?

Finding 21. The current human resources complement is not fit for purpose. The permanent staff complement is small and supplemented by short-term consultants. The high vacancy rate of permanent staff positions, primarily because of the lengthy recruitment process, presents a challenge for the Country Office to deliver on its mandate. The model of relying on short-term consultants is not optimal as it does not build continuity in the support provided by the Country Office to the Ministry of Health and Social Services. The turnover and disruption also undermine any effort to build core capacities within the Country Office.

The Country Office has a permanent staff complement (excluding the WHO Representative) of 25 permanent positions. Of these, 14 are directly involved in programmes and the remaining 11 are

support staff. The programme staffing is complemented by 12 short-term consultants and one UN volunteer.[9]

The permanent human resources complement is small, and the situation is exacerbated by the number of vacancies in the Country Office. On the programme side, only eight of the 14 positions are filled, representing just over half of the programme posts. There were vacancies for two international positions and four national positions by the end of December 2024.[10] In an office of this small size, these vacancies add to the workload of other staff. A case in point is the Health Promotion Officer who also acts as the Communications Officer. On the support side, one of the three driver positions is vacant. This has an impact on the mobility of staff, not only for meetings in the capital, but also for meetings in the regions.

Short-term consultants are appointed for specific projects to which funding is attached, and their contracts expire when the funding is depleted. A new source of funding then must be found to reappoint the short-term consultant. This adds to administration and disrupts the support provided to the Government. It creates discontinuity in the Country Office's relationships with the Government and other partners and stakeholders. Building and sustaining relationships with these persons and institutions is as important as providing the support.

Government partners and stakeholders expressed concern about the small staff complement, and even though they acknowledged that the Regional Office and WHO headquarters added to the capacities of the Country Office, it was necessary for the Country Office to have sufficient capacity and expertise to respond to the many requests from the Government for WHO support. There were suggestions from key informants in the Ministry of Health and Social Services that WHO consider having WHO technical staff embedded in the Ministry of Health and Social Services so that WHO support is readily accessible, and sustainable capacity can be built in the Ministry.

3.5 To what extent were the required financial resources mobilized and allocated efficiently to implement CCS priority interventions smoothly?

Finding 22. WHO mobilized the required financial resources for its core mandate as reflected by the four CCS III strategic priorities. Most base financing was allocated to Strategic Priority 1, while Strategic Priority 3 received a smaller proportion, suggesting a lower priority for health promotion. WHO mobilized resources timeously to respond to multiple public health emergencies, including the hepatitis E virus outbreak; the COVID-19 global pandemic (13 March 2020–2 March 2022); five Crimean-Congo haemorrhagic fever outbreaks in 2019, 2020, and 2023; and a drought that created a malnutrition crisis.

Table 8 shows the Country Office workplan funding (funds received) for the implementation of CCS III over the period 2018–2024. Of the total US$ 29.03 million available, 31.3% was allocated to Strategic Priority 1 and 26.3% was available for OCR, the latter largely reflecting the priority given to the COVID-

[9] Information provided by Namibia WHO Country Office, December 2024

[10] According to the Namibia WHO Country Office one international position was filled in early 2025.

19 pandemic response. Strategic Priority 4 received 18.2% of the workplan funding, Strategic Priority 2 received 11.9%, and Strategic Priority 3 received 6.5%. ESPEN received 1.9% of the available funds.

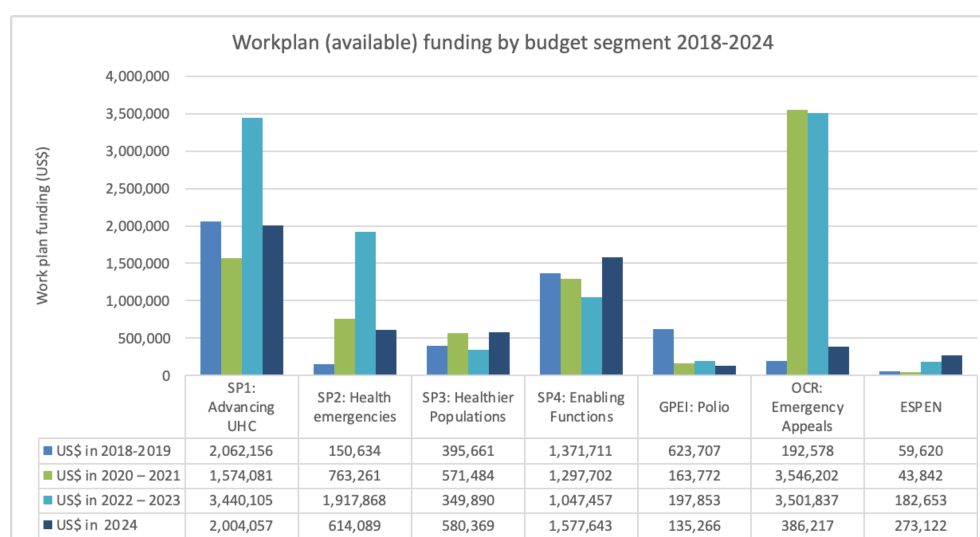
Table 8: Workplan funds by budget segment 2018–2024[a]

Budget segment	Workplan funds (US$)	Percent (%) of total workplan funds
SP1: Advancing UHC	9 080 399	31.3
SP2: Health emergencies	3 445 852	11.9
SP3: Healthier populations	1 897 404	6.5
SP4: Enabling functions	5 294 513	18.2
Global Polio Eradication Initiative	1 120 598	3.9
OCR: Emergency appeals	7 626 834	26.3
ESPEN	559 237	1.9
TOTAL	**29 024 837**	**100.0**

[a] Source*:* WHO Country Office in Namibia, April 2025.

Fig. 3 shows the distribution of workplan funds across the budget segments for each of the biennia and 2024. For each of the periods, Strategic Priority 1 received the largest share of funds available for the four strategic priorities. Strategic Priority 3 consistently received the smallest share of funding available for the strategic priorities. Strategic Priority 3 interventions are important for addressing determinants of health and reducing risk factors for NCDs and communicable diseases and attracts limited domestic and external funding, WHO should have considered an increased share of the base funding for Strategic Priority 3.

Figure 3: Amount budgeted by budget segment 2018–2024[a]



[a] Source: WHO Country Office in Namibia, April 2025.

In addition to the core work on the four CCS III strategic priorities, funds from WHO health emergency appeals for Namibia, especially for the COVID-19 response, constituted a significant share during the 2020–2021 and 2022–2023 biennia (Table 9). During the interviews, the Regional Office's Emergency

Preparedness and Response Cluster (EPR) and the Country Office's EPR interviewees underscored the challenge of non-prioritization in funds allocation for planned public health emergency prevention, mitigation and preparedness activities. Thus, when there are no significant public health emergencies or events in the country, EPR activities are not prioritized, and the Country Office experiences a dearth of funding for implementing the IHR-related prevention and preparedness activities in the EPR work plan.

Table 9: Funds mobilized: Emergency appeals 2018–2024[a]

Budget segment	2018–2019	2020–2021	2022–2023	2024
OCR (Emergency appeals)	192 578	3 546 202	3 501 837	386 217

[a] Source: WHO Country Office in Namibia, April 2025

3.4.1 Enablers of CCS achievements

Finding 23. Country ownership and leadership of the national health agenda facilitated the achievement of results in CCS III. Based on mutual trust, the strong partnership between the Ministry of Health and Social Services and WHO played a critical role in CCS III achievements, along with WHO's mandate and clear value proposition to the Government. Delivering as One WHO has been an important enabler of results.

The Government of Namibia demonstrated strong ownership and leadership of the national health agenda as evidenced through the policies, strategies and plans it introduced during the CCS III period, to achieve the national health goals and priorities set out in NDP5. Examples include the National Health Policy Framework 2024/25–2030, the National Action Plan for Health Security 2021–2025, and the Neglected Tropical Diseases Master Plan. The Government is keen to embrace innovation to improve the accessibility, efficiency and effectiveness of health services, as demonstrated in its adoption of the National eHealth Strategy 2021–2025.

WHO has developed a strong partnership with the Government of Namibia and the Ministry of Health and Social Services in particular. A key message from key stakeholders in government was that it valued the partnership it had with WHO that was based on trust and mutual respect. WHO's responsiveness to national needs and priorities was identified by government stakeholders as a key enabler or facilitator of achievements. While this highly responsive approach by WHO is an enabler, there is also the risk of WHO stretching its limited resources thinly in a bid to be responsive.

Delivering as One WHO has been a key enabler of results. The technical and financial support from the Regional Office, the Inter-Country Support Team for Eastern and Southern Africa, and the technical teams from WHO headquarters complemented the capacity, local knowledge and relationships of the Country Office. This enabled WHO to deliver more effectively than it would have had each level of the Organization worked in isolation from one another.

WHO has a clear value proposition for the Government and other stakeholders, namely, its technical expertise and normative mandate for health. A consistent theme from key informants was that with

WHO involvement in their work, the Government has the assurance that the technical guidelines, etc. are compliant with global standards. This trust in WHO's technical expertise has been a significant facilitator in the development and implementation of the many guidelines that WHO has supported in Namibia. WHO's public goods, including the data from the global and African health observatories, and evidence-based global strategies, guidelines and tools, are accessible to the Government and stakeholders and valued by them. These knowledge products and tools give engender confidence in WHO's support to Namibia.

3.4.2 Challenges to implementation

Finding 24. WHO experienced several challenges in the implementation of CCS III and fewer than 50% of planned interventions were fully implemented. The COVID-19 pandemic slowed down the implementation of some interventions as priority had to be given to supporting the response to the pandemic. However, other factors that preceded the onset of the COVID-19 pandemic also affected implementation. The main challenge was the insufficiency of human resources within the Country Office and the Ministry of Health and Social Services. Other challenges related to the paucity of intra- and inter-sectoral coordination mechanisms for health development also may have limited implementation.

Implementation status. The CCS III planned to implement a total of 91 interventions over the CCS III period. The evaluation team assessed the implementation status of these interventions. Across the four Strategic Priorities, 41 interventions (45%) were fully implemented, 39 interventions (43%) were partially implemented, and the remaining 11 interventions were not implemented, or no information was available on the implementation status.

Large number of CCS III interventions for small staff complement. The CCS III had 4 strategic priorities, 10 outcomes, 23 focus areas, and 91 interventions. The interventions were too many for a Country Office with a limited number of regular staff. Several key informants raised concern about the limited number of regular staff, the high turnover of programme staff on short-term and special service agreement contracts, and delays in contract renewal. These were seen to contribute to a lack of knowledge and skills transfer and insufficient time for staff to update their knowledge. At times, staff were multi-tasking in areas where they had limited knowledge, which contributed to delays in implementation. The issue of human resource constraints within the Country Office was raised as well in Country Office biennial reports.

Responding to multiple emergencies. WHO in Namibia responded to multiple public health emergencies, namely hepatitis E virus outbreaks in 13 out of Namibia's 14 administrative regions (2017–2021), the COVID-19 global pandemic (2020–2022), five Crimean-Congo haemorrhagic fever outbreaks in 2019, 2020, and 2023, and a drought that created a malnutrition crisis. These emergencies overstretched the limited number of Country Office and Ministry of Health and Social Services staff. The problem was compounded by the insufficient priority given to funding public health

emergency preparedness. The COVID-19 pandemic presented a major challenge to implementation. As was the case with many developing countries, Government and development partner resources were diverted to respond to the pandemic. In the case of Namibia, there was an increase in the number of health care workers, but these were for the COVID-19 response. As found by the UNPAF review, the diversion of resources to combat COVID-19 had a negative impact on health promotion and preventive services as it exacerbated already weak health promotion and preventive services.

Government staffing and allocations. Effective implementation of the CCS requires the Ministry of Health and Social Services to allocate its own resources efficiently and effectively. Examples include vacancies in the national TB programme, prevention of mother-to-child transmission and EPR activities. The human resources constraints of the Country Office are mirrored by human resource constraints within the Ministry of Health and Social Services. The Ministry of Health and Social Services does not have a standalone NTD programme, a dedicated NTD programme manager, or a dedicated NTD budget. This contributed to the delay (or lack) of implementation of some planned activities. Some Ministry of Health and Social Services directorates continue encountering challenges mobilizing coordinated multisectoral action and allocating adequate resources to implement approved strategic plans, for example, the National Malaria Strategic Plan (2017–2022) and the National Action Plan for Health Security *(34, 38, 39)*. The implementation of the National Malaria Strategic Plan was delayed by high staff turnover, underfunding, and lengthy procurement processes that affected the timely delivery of malaria commodities.

The 2024–2025 Health Budget Brief found that despite high per capita expenditure on health, the outcomes for health remained relatively constrained. Procurement inefficiencies, stock-out of essential health commodities, the tendency of health service users to bypass PHC facilities because of quality concerns, the high cost of providing services in remote or sparsely populated locations, and the public subsidy for private health insurance were among the key factors identified as contributors to spending inefficiency *(68)*.

Limited scope for mobilizing external financial resources. A theme raised consistently by key informants was the limited donor funding available to Namibia that impacted negatively on the Government's ability to fully implement the policies and strategies that had been developed. Since Namibia's previous graduation to upper middle-income country status, it became ineligible for grants from donors such as Gavi, the Vaccine Alliance, and the number of development cooperation partners has declined. Funds from the Global Fund have also declined in volume from US$ 69.67 million in grant cycle 6 to US$ 34.05 million in grant cycle 7 *(69)*. The recent withdrawal of the United States Agency for International Development and the United States Centers for Disease Control and Prevention, two major partners in Namibia's health sector will see a further decline in external financial resources, at least in the short term. This will require the Government to look how best it can mobilize domestic sources of revenue and use these resources more efficiently.

Health sector coordination. Namibia has not yet established a SWAp for coordinating health sector stakeholders from the national to district (or at least regional) level. The Ministry of Health and Social Services does not have a structure coordinating all stakeholders in the health sector. Instead, there

are multiple coordinating structures for the different initiatives, and this is not efficient for the Namibian context with relatively small government ministries and small numbers of external stakeholders. For example, Namibia had a multisectoral HiAP technical committee that has been coordinating inputs from 22 government entities into the development of the National Strategy for the Implementation of Health in All Policies. The policy development process started in 2017 with WHO support and at the time of the evaluation, the HiAP strategy had not been approved for implementation by the Ministry of Health and Social Services.

Limitations of CCS monitoring and evaluation. There were gaps in the CCS III results framework. While the results framework contained measurable outcome indicators, it lacked intermediate (output) indicators that would have been useful in assessing the effectiveness of the interventions planned for each biennium. These intermediate indicators would also have been useful for a more results-orientated biennium report that explains the results of the interventions implemented in the biennium. It would also have been useful for WHO to commission evaluations of one or two major interventions per biennium for generating knowledge and learning about these interventions.

3.5 Sustainability

Key evaluation question 4. To what extent has WHO contributed towards building sustainable national capacity of institutions and relevant government structures to lead the health development agenda?

4.1 To what extent have WHO interventions supported national ownership for health system strengthening, as well as the national capacity to deliver on and achieve the results as planned in the relevant national health policies and strategies? Is there evidence that the benefits will be sustained over time?

Finding 25. WHO interventions further strengthened national ownership of the health agenda and health systems strengthening. The Organization has acted as an enabler, supporting the Government to lead the national health agenda. The evaluation found good examples of WHO's contribution to building sustainable institutional capacity by strengthening the policy frameworks and strategies. Lack of adequate resources for the implementation of policies and strategies developed with WHO support undermines sustainability.

National ownership and political commitment. The Government of Namibia through the Ministry of Health and Social Services is committed to the CCS III interventions as they are strongly aligned with national priorities. The Ministry of Health and Social Services undisputedly leads and owns the health agenda in Namibia. Political will and commitment to the health agenda is demonstrated in the financial investments the Government makes in the health of its citizens. The recent announcements of increases in the number of positions for the health sector and the adoption of the National Policy on Universal Health Coverage are examples of political will and commitment displayed by the Government. The role of WHO has been that of an enabler to the Ministry of Health and Social Services, working in close partnership with the ministry and providing the technical expertise required

and requested. WHO is seen by government partners as a trusted partner that guides through its expert advice and does not impose.

Integration into the national health ecosystem. Much of the technical support to Namibia has been to review or develop policy and legislative frameworks, strategies and technical guidelines. Even though there have been delays in finalizing these instruments, they are an integral part of the formal institutional framework for health in Namibia. In this sense, they will endure or be sustainable for as long as they are in existence and used and until they are overtaken by changes in the country context. The evaluation found examples of policies, strategies and frameworks developed with the support of WHO that are being implemented. The National Quality Management Policy 2021, the National Quality Management Strategic Plan 2021/22–2025/26 and the National Quality of Care Monitoring and Evaluation Framework are good examples of integration into the public health system. Another example is the use of the National Malaria Elimination Strategic Plan 2023–2027 by the Ministry of Health and Social Services effective use to secure US$ 3.093 million for malaria elimination from the Global Fund. Namibia is also piloting digital health modules as part of implementing the National eHealth Strategy.

Building on COVID-19 experience. The Government has used the experience and support from WHO during the COVID-19 pandemic to strengthen its preparedness for future public health emergencies. The launch of the new Multi-Hazard Emergency Preparedness and Response Plan in 2024 is a case in point. The Government is also strengthening its risk communication systems.

Other factors affecting sustainability. There were other factors affecting sustainability. Government financing to implement the policies and strategies developed with WHO support is a major factor impacting sustainability. The issue of financing policy and strategy implementation was raised by several key informants and confirmed in the evaluation's assessment of CCS III achievements. The recent withdrawal of a major development partner presents a threat to sustainability, unless alternative sources of financing are found. Prior to the withdrawal, the development partner was working with the Ministry of Health and Social Services on a sustainability plan.

Introducing new policies and approaches in a context where key national legislation has not yet been drafted undermines sustainability, as they are not anchored in a sound legislative framework that is aligned to international standards. Important legislation such as the Public and Environmental Health Act 1 of 2015 has yet to be implemented, although parts relating to emergencies have been promulgated to enable the COVID-19 response. There are also outdated pre-independence laws that are at odds with NDP5 and may be perpetuating inequalities in health. Although there is the stated intention to replace these laws, the process to do so has been slow. An example is the Blood Transfusion Act of 1962, which needs to be replaced to align fully with international standards.

4.2 What are the key lessons learned and unfinished agenda for consideration in the five-year strategy?

Finding 26. In addition to lessons learned from the COVID-19 pandemic, two key lessons learned from the implementation of CCS III are (a) the importance of prioritization when designing the next CCS and (b) that capacity building interventions should be designed with sustainability in mind. There is a substantial unfinished agenda that needs to be considered for the next CCS. Among these are continued support for implementation of the National Policy on Universal Health Coverage, data and digital health, addressing the rise in NCDs and mental health, and strengthening health promotion.

The implementation of CCS III generated key lessons, especially during the COVID-19 pandemic. These have been discussed in question 3.2 on WHO's role in the COVDI-19 response. In addition to the lessons from the COVID-19 pandemic, the design and implementation of CCS III hold other key lessons for WHO for consideration in developing the next CCS.

CCS III had too many interventions relative to the delivery capacity of the Country Office. A key lesson for the next CCS is to design a more focused CCS by adopting a theory of change approach and thorough prioritization, grounded in evidence about the criticality of the health issues, whether WHO has a comparative advantage in a particular area, and whether WHO has the capacity to deliver.

The analysis of the implementation status of the CCS III interventions suggests several areas of unfinished business that may need to be taken forward into the next CCS. There were also proposals from key informants for areas that required support from WHO in the next CCS. The unfinished agenda includes the following:

- The National Policy on Universal Health Coverage took years before it was finally adopted by the Cabinet. The implementation of this policy will require a comprehensive plan and framework for implementing and financing, and mobilization of stakeholders to support its financing and implementation.
- The rollout of quality standards in all the hospitals and PHC facilities needs continued support with a focus on sustainability.
- Data, information systems and digital health require attention. With the expiry of the National eHealth Strategic Framework in 2025 and new developments, such as artificial intelligence, a review of the strategy is required. An overarching health information systems policy needs to be developed to address the existing fragmentation. Namibia's National Health Research Strategic Framework needs to be finalized and implemented. Policies have weak or no monitoring and evaluation frameworks and capacity is needed for developing these frameworks.
- Namibia's National Health Care Technology Policy March 2003 (including infrastructure) needs review and updating, and the Policy on Construction of Health Facilities (health infrastructure) needs to be developed.

- NCDs were identified by several key informants as an area for increased attention in the next CCS.
- The National Health Promotion Policy and the National Strategy for The Implementation of Health in All Policies, once approved by the Government, will need support to accelerate action against the environmental and social determinants of health and the risk factors for communicable and NCDs.

3.6 Cross-cutting issues

Key evaluation question 5. To what extent did WHO address the needs and rights of vulnerable populations, especially those at risk of being the furthest left behind?

5.1 To what extent did the Country Office's support and interventions consider the needs and rights of vulnerable populations, including women, children, older persons, persons with disabilities, the poor, persons with disabilities, people living with HIV, groups in remote areas, and migratory groups?

Finding 27. The principles of health equity, the needs and rights of vulnerable population, and gender equality are an integral part of WHO's mandate and functions in Namibia. The evaluation found several examples of these principles in the interventions implemented under CCS III. WHO's support included actions targeting women, children, people living with HIV, and underserved populations in rural and remote areas. However, given the breadth of WHO's work—91 key interventions over the CCS III period—it was not feasible to assess each intervention in depth. As such, while evidence indicates that these principles were considered in many activities, the extent of their integration across all interventions could not be comprehensively verified.

WHO's interventions under Strategic Priority 1: UHC were centred around health equity. Interventions on quality care aimed to ensure that all users of the public health system received quality health care, whether they live in urban centres, or in the remote parts of the country. The National Policy on Universal Health Coverage approved by the Cabinet in 2025 aims to ensure that all citizens can access needed health services without financial hardship. WHO has been advocating for this over the CCS III period and its support to the National Committee on Health Financing and Financial Protection contributed to the policy.

WHO support to a wide range of RMNC, adolescent health, and nutrition interventions, including the Family Planning Guidelines and the Comprehensive Post-Abortion Care Guidelines, addressed the issue of women's SRH rights. Interventions in HIV, including elimination of mother-to-child transmission of HIV, and scaling up the integration of SRH and HIV/AIDS services are additional examples of WHO addressing women's health and maternal health.

WHO supported interventions targeting migratory groups and groups living in remote areas. For example, the quality management programme was rolled out to the remote Kunene region, which has a significant migratory population.

WHO provided technical support to the Ministry of Health and Social Services to develop the National Policy on the Rights, Care and Protection of Older Persons. The Ministry of Health and Social Services, with WHO support, convened consultations on the draft policy in November 2022 and planned to complete the policy in the first quarter of 2023 *(70)*. The policy was not finalized at the time of the evaluation. The Ministry of Health and Social Services indicated that they required technical assistance to cost the implementation of the policy and prepare draft legislation to give it effect.

WHO interventions had limited coverage of persons with disabilities. WHO supported the National Systematic Assessment of Rehabilitation Situation to guide the development of the first National Rehabilitation and Assistive Technology Strategic Plan, which included rehabilitation and assistive technology for persons with disabilities.

4 Conclusions

WHO made a significant and valued contribution to Namibia's health sector during the CCS III period. The Organization effectively leveraged its normative mandate and comparative advantage as the lead UN agency for health, providing timely and credible support—particularly in responding to health emergencies such as the COVID-19 pandemic. WHO remains a trusted and strategic partner of the Government of Namibia, contributing meaningfully to national health priorities and systems strengthening. The evaluation identified multiple successes across strategic priorities, while also highlighting areas for improvement, particularly in the resourcing, coordination, and continuity of technical support.

Conclusion 1.

WHO reinforced its strategic positioning as the leading health agency in Namibia, by building on its longstanding partnership with the Government, particularly through the Ministry of Health and Social Services. Its continuous engagement with government counterparts—at both the political and administrative levels—enhanced its role as a trusted adviser on key health issues. WHO's support remained highly relevant and aligned with Namibia's national health and development priorities throughout the CCS III period. The profile of WHO was significantly elevated during the COVID-19 pandemic, when its comparative strengths in mobilizing resources, specifically during health emergencies, and convening diverse stakeholders were clearly demonstrated. WHO's leadership and technical guidance during the crisis further solidified its position as a critical partner in Namibia's health landscape.

Conclusion 2.

WHO was effective in achieving results over the CCS III period, although the extent of success varied both across and within strategic priorities. Notably, positive changes were observed in the CCS

outcome indicators for Namibia under Strategic Priority 1 (UHC) and Strategic Priority 2 (Health Emergencies). These areas received the majority of WHO's financial and human resource investments, making it plausible that WHO contributed significantly to the progress achieved. In contrast, progress under Strategic Priority 3 (promoting healthier populations) was limited. While the COVID-19 pandemic posed a significant challenge, the persistent under-resourcing of Strategic Priority 3 throughout the CCS III period was a key constraint to achieving intended outcomes. To maximize impact, WHO should leverage the UNSDCF to better align its health interventions with broader UN efforts, promoting integrated and multisectoral approaches to health and development in Namibia.

Conclusion 3.

By the end of 2024, a substantial unfinished agenda from CCS III remained, such as human resources development, strengthening health information systems and e-health, procurement capacity, progress toward UHC, NCD prevention and malaria elimination, reducing child malnutrition, and scaling up adolescent-friendly and gender-based violence services—largely due to resource constraints. A significant decline in external (donor) funding limited the Government's capacity to implement the policies and strategies developed with the support of WHO and other development partners. This reduction in financial support contributed to the slow progress in translating strategic guidance into concrete action. The recent precipitous reduction in some donor's development assistance funding presents challenges for the country and its health sector, as well as opportunities for WHO to discuss with national counterparts the types of assistance required.

Conclusion 4.

CCS III was ambitious in scope and designed more as an operational framework than a strategic framework to guide actions. Furthermore, the framework was not grounded in an explicit theory of change, and the accompanying monitoring and evaluation framework lacked intermediate outcome indicators. This limited the ability to clearly demonstrate WHO's contribution to improvements in the health sector.

Conclusion 5.

The staffing of the Country Office was not commensurate with the extensive portfolio of planned interventions of CCS III. Prolonged vacancies in senior positions placed additional workload on existing staff, requiring them to assume multiple roles beyond their core responsibilities. The reliance on short-term consultants to supplement the limited number of permanent positions created discontinuities in both implementation and sustained engagement with government ministries, departments, and agencies.

5 Recommendations

Ensuring continuity between CCS III and CCS IV

Strategic and results-oriented development of CCS IV (2026–2030)	
Recommendation 1	WHO in collaboration with the Ministry of Health and Social Services and other key health stakeholders should develop and finalize CCS IV (2026–2030) by the fourth quarter 2025, aligning with Namibian National Development Plan health priorities and WHO's GPW14 strategic outcomes where it has a clear comparative advantage in the country. Furthermore, CCS IV should contain a robust Theory of Change and monitoring and evaluation framework that includes intermediate outcomes and indicators to better capture results that can be attributed to WHO.
Priority actions	1.1 **Establish strategic focus and causal pathways for CCS IV:** Structure CCS IV as a strategic framework with clearly defined priorities and an explicit theory of change to clarify the pathways through which WHO's inputs and activities are expected to lead to health outcomes. 1.2 **Align CCS IV with national and global health priorities:** Ensure alignment of CCS IV with national health priorities as outlined in NDP6, Namibia's National Health Policy Framework 2024/25–2030, and GPW14. 1.3 **Strengthen monitoring and evaluation to demonstrate WHO's contribution**: Develop a monitoring and evaluation framework for the CCS that includes intermediate outcomes and indicators to better capture results that can be attributed to WHO. 1.4 **Strengthen alignment and adaptation through joint planning and review:** Leverage joint biennial planning and review processes to align Government expectations with WHO's capacity and to adjust priorities in line with available resources. 1.5 **Review and adapt the CCS for continued relevance and responsiveness:** Conduct a midterm review of the CCS to ensure it remains relevant and responsive to evolving country needs and contextual changes
Link to conclusions	Conclusion 1, 2, 3, 4, 5
Lead/Responsibility	**WHO Country Office**, WHO Regional Office for Africa, WHO headquarters, United Nations Country Team, Ministry of Health and Social Services
Priority/Timeline	High/2025 from start of CCS design

Strengthening equity and impact through scaled support to under-resourced health priorities	
Recommendation 2	WHO should consolidate gains in well-performing areas while scaling up support in under-resourced domains to enhance outcome- and system-level impact. This includes maintaining momentum in UHC and

	emergency preparedness, while intensifying efforts in NCDs, health promotion, and health information systems. Priority actions and resource planning for these areas should be initiated in the first year of CCS IV implementation (2026) and reviewed annually to ensure continued relevance and progress.
Priority actions	2.1 **Strengthen UHC implementation planning:** Support the Ministry of Health and Social Services in developing and operationalising a costed implementation plan for UHC, including mapping and aligning WHO normative guidance and technical support with national UHC priorities; facilitating multistakeholder consultations to define priority actions, costing assumptions, and timelines; and providing technical assistance in budgeting, costing tools, and results-based planning. 2.2 **Enhance health information systems and data use:** Support the Ministry of Health and Social Services in consolidating and expanding national health data systems by integrating fragmented data sources, improving real-time reporting capabilities, and strengthening institutional capacity for data analysis and use. This includes supporting the finalization and implementation of the National Health Research Strategic Framework to strengthen evidence-informed policymaking and strategic planning. 2.3 **Collaborate with the Ministry of Health and Social Services to develop and implement a costed national action plan for NCD prevention and control:** The plan should include the following key elements: expanding screening services and improving access to care; implementing targeted behaviour change interventions, with particular focus on reducing tobacco and alcohol use among high-risk populations; and supporting the Government in mobilizing domestic and partner resources to scale up evidence-based health promotion activities, with a focus on mental health, child nutrition, and behaviour change communication. This includes full rollout of the Integrated School Health and Safety Policy and community-based health literacy campaigns. 2.4 **2.4 Reinforce the implementation and monitoring of communicable disease action plans:** Continue supporting the Ministry of Health and Social Services to fully implement, monitor and review national action plans for combatting communicable diseases to accelerate progress and reduce the risk of backsliding in areas such as neonatal mortality, maternal mortality, child mortality, HIV, TB, and malaria.
Link to conclusions	Conclusion 2, 3
Lead/Responsibility	**WHO Country Office**, WHO Regional Office for Africa, WHO headquarters
Priority/Timeframe	High/feeds into first biennial work plan of CCS IV

Implementing CCS IV (2026—2030)

Strengthen collaboration with UN agencies and multistakeholder and multisectoral partnerships	
Recommendation 3	WHO should strengthen its collaboration with UN agencies contributing to relevant health outputs under the UNSDCF and expand multisectoral partnerships beyond the Ministry of Health and Social Services over the next 12–18 months. This includes supporting joint actions, advocating for integrated approaches to health, and actively engaging with other sectors.
Priority actions	3.1 **Promote joint UN collaboration:** Engage with relevant UN agencies to identify opportunities for joint action that contribute to UNSDCF health outputs. Those may include joint support missions to regions, collaborative capacity building workshops, and coordinated resource mobilization. 3.2 **Support sector coordination and HiAP:** Explore and support the feasibility of transitioning to a SWAp for the health sector, with government leadership, to improve coordination, alignment, and harmonization among health stakeholders. This includes reviewing the structure and function of the Health Development Partners Forum to assess its potential role within a SWAp framework. Additionally, advocate for the establishment of a formal multisectoral coordination mechanism as envisaged in the draft National Strategy for the implementation of HiAP. 3.3 **Strengthen engagement with non-State actors:** Review existing partnerships with civil society, the private sector, private foundations, and academic and research institutions and identify opportunities for enhanced collaboration (in line with FENSA requirements). 3.4 **Improve intra-ministerial coordination:** Facilitate the establishment of a formal coordination mechanism – such as a joint planning and review committee – between the Health Promotion Unit and the Social Services Division of the Ministry of Health and Social Services. This mechanism should aim to align priorities and enhance data sharing and implementation of integrated community-based interventions. 3.5 **Advocate:** Advocate, in coordination with national health development partners, for increased and equitable allocation of the national budget to the health sector by the Government of Namibia.
Link to conclusions	Conclusion 2, 3 and 4
Lead/Responsibility	**WHO Country Office**, United Nations Country Team
Priority/Timeline	Medium/2025

Strategically align and optimize human and financial resources for enhanced impact	
Recommendation 4	To ensure efficiency and impact, the WHO Country Office should optimize the use of its financial and human resources over the next two years. To do so, it should strengthen the strategic allocation and monitoring of resources by aligning staffing and budgets with priority health outcomes, enhancing planning processes and resource mobilization, and regularly reviewing resource utilization.
Priority actions	4.1 **Conduct a strategic workforce review:** In the context of financial constraints faced by WHO, and aligning with CCS priorities, undertake a strategic review of staffing needs to determine optimal skill mix, identify critical gaps, and inform medium-term workforce planning.

	4.2 **Increase funding for under-resourced areas:** Given the persistent underfunding of Strategic Priority 3 (promoting healthier populations), WHO should develop a targeted resource mobilization strategy to attract traditional and non-traditional donor funding, especially for under-funded areas such as health promotion and disease prevention interventions. 4.3 **Enhance financial monitoring and efficiency:** Implement regular internal reviews of fund utilization across strategic priorities to promote efficient allocation. Establish mechanisms to apply corrective actions where funding remains consistently low in key health areas.
Link to conclusions	Conclusion 5
Lead/Responsibility	**WHO Country Office**, WHO Regional Office for Africa, WHO headquarters
Priority/Timeframe	Medium/2025

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Annex 1: Terms of Reference

Terms of Reference
7 November 2024

1. Introduction

In line with the World Health Organization's (WHO) 2018 Evaluation Policy (1) and implementation frameworks (2), the independent evaluations of WHO contribution at the country level are included in the biennial WHO organization-wide evaluation work plan, approved by the Executive Board. These evaluations aim to review WHO's performance and contributions to countries' national health priorities and needs, in the context of other partners' contributions, to promote the national public health agenda and the population's well-being. Furthermore, they focus on the results achieved at the country level using the inputs from all three levels of WHO, documenting key contributions, best practices, gaps and lessons. They provide insights into the strategic direction WHO needs to take going forward to better support the member state (Namibia in this case).

At the global level, the WHO Thirteenth General Programme of Work 2019–2023 (3) and extended to 2025 (4), and at the country level, the WHO Country Cooperation Strategy (CCS) for Namibia 2018—2022 (extended to 2023) have guided the work of the WHO Country Office in Namibia for quality and effective support to the attainment of national health goals. The 2018—2023 CCS was aligned to country strategic documents, specifically the Fifth National development plan at the macro level, the National Health Policy Framework 2010—2020 (5), and disease specific strategies at the sector level. Within the United Nations (UN) family, the CCS contributed to the United Nations Partnership Assistance Framework (UNPAF) (2019-2023 extended for an additional year) (6), which guided the work of the UN in the country. The biennial workplans implemented the aspirations of the CCS through two-year planning cycles.

This evaluation is timely: The organization is transitioning into the Fourteenth General Programme of Work (GPW 14), which starts in 2025, and the WHO Country Office in Namibia is embarking on the development of a new CCS starting 2025. The lessons and evidence emerging from the evaluation will inform the development of the new CCS and facilitate identification of areas that can be re-prioritized to ensure the relevance and appropriateness of interventions consistent with stakeholder needs, as well as the broader goals of WHO's normative work and core functions.

An internal review of the performance against the 2018—2023 CCS objectives was carried out in 2022 and showed significant progress in the realization of the overall goals and strategic objectives set out in the CCS III, with some varied performance (please refer to Appendix A).

This evaluation will further inform the required adjustments to ensure strategic alignment and a fit for purpose WHO country office, and to guide future resource mobilization efforts. Additionally, the

arrival of a new WHO Representative in Namibia in 2024 presents an opportune moment for strategic alignment and recalibration of WHO's interventions and positioning in the country.

2. Country and health context

2.1 Country context

Namibia is an lower middle-income country with a GDP per capita of US $4,413.13 (7)). The country registered improved economic growth of 4.2 % in 2023 while growth between 2024 and 2026 is projected as moderate at 3.0–3.8%. Poverty and inequality levels in Namibian are significant. Poverty is higher in rural areas (37%) than urban ones (15%) and higher among women (32%) than men (26%). According to the 2021 Multidimensional Poverty Index, 43.3% of the Namibian population are multidimensionally poor. Namibia is one of the most unequal countries in the world with a Gini index of 63.3 in 2022. Unemployment remains at 19.63% in 2023 (8).

The country has a population of approximately 2.6 million people as of 2021, and this is projected to be 4 million by 2050, with the annual growth rate projected to decrease from 1.8 percent in 2020 to 1.0 percent by 2050 (9). The population is relatively young, with a median age of 22 years, and 64 percent of the population under 30.

2.2 Health context and system

Over the past decade, life expectancy at birth has improved from 53 years in 2000 to 60.4 years in 2021. The trend in health-adjusted life expectancy at birth also shows an improving trend, increasing from 46.7 years in 2000 to 52.8 years in 2021 (10). The country faces a double burden of disease with communicable diseases as the leading causes of death and increasing trends of noncommunicable disease (NCD), trauma, and injuries as causes of death.

Public health services are provided through one national referral hospital, four intermediate hospitals, 36 public district hospitals, 43 health centres, 302 clinics and more than 1000 outreach points. Access to health services is notably good, with 76% of the population living within the WHO-recommended 10 km radius of a health facility. Health worker-population ratio has consistently remained at 3.0: 1000, above the WHO benchmark of 2.5 : 1000. However, the available health workforce is skewed towards urban areas and the private sector. The health system is predominantly tax funded and government expenditure on health stands at US$ 217 per capita. Government health expenditure as a percentage of current health expenditure stands at 48%. In comparison, in 2009, only 1.22% of households in Namibia spent more than 10% of the total household budget on health. In 2022, the service coverage index for Namibia was estimated at 61, up from 59 in 2017 (11).

3. Evaluation object

The object of this exercise is to evaluate the contribution of WHO in Namibia, both in terms of achieving planned results in the current strategic period, and in terms of its role going forward. Planned results for WHO in Namibia are framed in the CCS for the period 2018-2023. The CCS is a document to guide WHO's work in countries. It is a medium-term vision for WHO's technical cooperation with a given Member State, and supports the country's national health policy, strategy or plan.

The Namibia CCS 2018-2022 (extended to 2023) priorities were identified from the National Health Sector Strategic Plan (NHSSP) and aligned fully with the health-related sustainable development goals (SDGs) and the WHO Thirteenth General Programme of Work 2019–2023 (GPW 13). The CCS sought to achieve the three interconnected core objectives of (a) advancing universal health coverage, (b) addressing health emergencies, and (c) promoting healthier populations; and for the crosscutting objective of strengthening leadership, governance and enabling functions. All these aimed at ensuring healthy lives and well-being for all people at all ages in Namibia.

The CCS was implemented through biennial workplans that were developed through a consultative process with the Ministry of Health and Social Services and health development partners. The participatory planning process of biennial workplans was aligned to the Ministry of Health and Social Services's strategic plan, the United Nations Partnership Assistance Framework (UNPAF) (2019—2024) and took into consideration GPW 13 and regional priorities, ensuring that WHO's work was translated at the country level.

- *Appendix A shows the main WHO interventions in Namibia as detailed in the CCS for the period 2018—2023.*
- *Appendix B provides a summary of the performance of all the indicators identified in the results framework of the CCS.*

The WHO Country Office in Namibia has supported Ministry of Health and Social Services's leadership in their engagement in governance body meetings, regional committees, and the World Health Assembly. Regarding health leadership, the Country Office is a member of the UN Country Team, the health development partners, and the United Nations Partnership Framework. The Country Office also chairs the Health Development Partners Forum.

4. Funding the WHO Namibia country's programmes

Table A1.1 presents financing levels and utilization of funds across the Country Office's budget segments over the period 2020—2025.

Table A1.1. Funding the WHO Country Office in Namibia

	2020—2021		2022—2023		2024—2025		Total Period	
Budget segment	Funds Received	Utilization	Funds Received	Utilization	Funds Received	Utilization	Funds Received	Utilization
BASE	4 178 466	4 113 448	6 361 274	6 360 836	3 587 035	2 299 216	14 126 775	12 773 500
OCR	3 318 287	3 287 197	3 860 837	3 860 831	-		7 179 124	7 148 028
Special Programme (ESPEN)			182 653	182 653	273 121	242 677	455 774	425 330
Polio	129 671	121 389	195 150	195 149	50 000	34 469	374 821	351 007
TOTAL ($)	**7 626,424**	**7 522 034**	**10 599 914**	**10 599 469**	**3 910 156**	**2 576 362**	**22 136 494**	**20 697 865**

Donors at country level include the government of Japan, Sight Savers, the United Nations Office for Project Services, the Government of Iceland, and the Ministry of Foreign Affairs of the Republic of Korea.

5. Evaluation purpose and objectives

The purpose of this evaluation of WHO contribution in Namibia is to support organizational learning and accountability for results towards WHO's external and internal stakeholders. It provided an opportunity to synthesize insights gained from what worked and what could be done differently, and to offer evidence-informed insights to support the development of new strategic direction, including the new CCS. This will be a formative (forward-looking) evaluation to support the Country Office and national stakeholders' strategic learning and decision-making for the next CCS. Additionally, this evaluation will have a secondary summative (backward-looking) perspective, to support enhanced accountability for the achievement of planned results and learning from experience.

5.1 Evaluation objectives

1) Assess the extent of alignment of WHO's work to Namibia's national health strategies, priorities and evolving needs.
2) Analyse the key achievements of WHO against the objectives formulated in the CCS (refer to the CSS review) and corresponding expected results developed in Country Office biennial work plans, while pointing out the key success factors, gaps, challenges, and opportunities for improvement.
3) Assess WHO's work on driving impact at country level and its contribution towards to enhancing public health.

4) Identify lessons learned from WHO's work to inform development and resourcing of the next CCS and operational planning.
5) Assess the adequacy of WHO resources (human and financial) to attain set targets and make impactful contribution to the health agenda of the country.
6) Recommend required programmatic adjustments to realize a fit for purpose WHO to enhance the impact and relevance of WHO's work in Namibia.

6. Evaluation scope

The evaluation will cover interventions across all outcome areas undertaken by WHO in Namibia, with support from Regional Office and Headquarters during the 2018—2024 period, as defined in the CCS and relevant programmatic instruments, such as biennial workplans.

In addition, the evaluation will look at the way WHO addresses equity and ensures that all population groups are given due attention in the various policies and programmes. Cross-cutting thematic issues of gender equality, health equity, human rights, and disability inclusion will also be assessed.

The evaluation will review relevant data over the period 2018—2024.

The geographical scope is the national and regional levels in Namibia. The fieldwork phase might involve visiting some regions where the Country Office has implemented activities.

7. Users of the evaluation

The intended users of this evaluation are internal (all WHO levels) and external (government counterparts, partners, and CSOs) stakeholders. Table A1.2 details evaluation roles and interests.

Table A1.2. Evaluation stakeholders' roles and interests

Internal	Role and interest in the evaluation
WHO Country Office in Namibia	Evidence from this evaluation will inform the development and implementation of the next country strategy. It will serve as the baseline for GPW14 for the Country Office and for subsequently monitoring implementation progress and will inform resource mobilization and future WHO contributions.
WHO Regional Office for Africa	The Regional Office is responsible for ensuring that WHO's contribution at the country level is relevant, coherent, effective, and efficient. The evaluation findings and best practices will inform other country offices in the region, as well as regional approaches to health.
WHO headquarters	WHO headquarters oversees the strategic analysis of the content of country-level strategic instruments and their implementation. It is also responsible for promoting the application of best practices in support of regional and country technical cooperation.
External	

WHO Regional Committee for Africa and Executive Board	The Regional Committee and Executive Board have a direct interest in being informed about the added value of WHO's contribution at the country level, best practices, and challenges through the annual Regional Committee and evaluation report.
Government of the Republic of Namibia	As a recipient of WHO's action, the Government has an interest in the partnership with WHO, and an interest to see WHO's contribution to the country's health independently assessed. The Government will be engaged in the external review group, and in consultations, validation, a stakeholder workshop, and the use of evaluation recommendations.
Namibians including healthcare providers	WHO's action in country must ensure that it benefits all population groups, prioritizes the most vulnerable, and does not leave anyone behind. The evaluation will look at the way WHO addresses equity and ensures that all population groups are given due attention through the various policies and programmes. Stakeholders from the health sector and other relevant fields will be engaged during data collection as respondents.
UN Country Team	As part of the UN Country Team, WHO contributes to UN strategic frameworks. It is in the Country Team's interest to know about WHO's achievements and best practices in the health sector and to identify partnership opportunities. The Country Team will be engaged as part of external review group, as key informants, and through the stakeholder workshop.
Donors and partners	Donors have an interest in knowing whether their contributions have been spent effectively and if WHO's work contributes to their strategies and programmes. Donors will be engaged through Namibia's in-country stakeholder workshop. Partners will be engaged through interviews at the data collection stage, and as part of the evaluation reference group. Findings will be shared at meetings of the Health Development Partners Forum.

8. Evaluation questions

Based on the objectives, the following indicative evaluation questions (Table A1.3) are proposed and will be reviewed and finalized during the inception phase by the evaluation team in agreement with the Evaluation Management Group and Evaluation Reference Group after discussions with key stakeholders and the inception stage document review.

Table A1.3. Evaluation questions

Criterion	Key Evaluation Questions	Sub-questions
Relevance	1. To what extent is the Country Office's positioning, level of engagement, organizational structure and interventions aligned to the national context and the evolving needs, policies, and priorities of the Government, and to the needs and rights of Namibians?	1.1 To what extent is the Country Office's support and interventions aligned to the national policies and priorities and evolving health needs and development priorities of Namibia? 1.2 To what extent are WHO interventions aligned externally to the United Nations Partnership Framework (UNPAF) 2019-2023? 1.3 To what extent are Country Office interventions aligned with Regional Office priorities, GPW13 as well as to other related global sector-specific policies and resolutions? 1.4 To what extent is the current human resource complement fit for the level of health system of the country and required technical assistance?
Coherence	2. To what extent have WHO interventions and	2.1 To what extent are Country Office interventions and implementation approaches integrated and

	implementation approaches integrated and demonstrated synergies and complementarity with one another as well as with interventions carried out by other partners and the Government in Namibia?	synergized internally, and complimentary to partner interventions? 2.2 How has WHO harnessed its comparative advantage to deliver on its mandate, particularly in its roles as a health leader and convening and coordinating partner; and how has it positioned itself as a strategic partner in the Namibia context?
Effectiveness, efficiency	3.To what extent were WHO results (including contributions at the outcome and system level) achieved or are likely to be achieved and what factors influenced (or did not influence) their achievement?	3.1 What were WHO's key achievements during this CCS period? 3.2 What factors explain the attainment (or lack thereof) of planned CCS objectives? 3.3 What challenges were faced in implementing the current CCS? As the Country Office embarks on developing the next CCS and starts implementation of GPW14, what are the priorities in the short to medium term? 3.4 What has been the added value of WHO Regional Office and headquarters contributions to the achievement of results in Namibia? 3.5 Did the Country Office adopt efficient implementation approaches, such as a strategic approach to technical assistance?
Sustainability	4.To what extent has WHO contributed towards building sustainable capacity of national institutions and relevant government structures to lead the health development agenda?	4.1 To what extent has WHO supported Namibia's national longer-term goals and built health security and system resilience? 4.2 To what extent have WHO interventions supported national ownership for health system strengthening, as well as the national capacity to deliver on and achieve the results as planned in the relevant national health policies and strategies? Is there evidence that the benefits will be sustained over time?

9. Design, approach and methodology

The methodology outlined in this section is indicative and evaluators are encouraged to adapt and integrate the approach and propose any adjustments needed to adequately meet the evaluation purpose, objectives, scope, and questions during the inception phase, noting the methodological limitations and corresponding mitigation measures.

9.1 Evaluation design and approach

While adopting mixed methods, it is envisaged that the evaluation will be theory-based using a rigorous and transparent methodology to address the evaluation questions. Participatory, learning, and utilization-focused approaches will be used, including engaging with the principal users of the evaluation process and report—the WHO country and regional offices, key stakeholders, and focal points in national government ministries and departments, representatives at the national level as far as possible, and UN partner organizations in Namibia. By engaging key evaluation stakeholders to promote participation, ownership, and utilization of the evaluation, the evaluation team should strive to provide immediate feedback to the Country Office, so that learning can be iterative, and

improvements can be easily identified and absorbed. The evaluation could adopt an approach based on the contribution, rather than the attribution, of WHO interventions to health development outcomes and impact results in Namibia by considering WHO interventions around the four CCS priorities. Evaluators can consider the contribution analysis, particularly around questions of effectiveness, and other relevant approaches for stakeholder consultation that could generate useful qualitative and quantitative data on key issues.

During the inception phase, the evaluation team will design the methodology which will entail the following:

- Develop a theory of change for the evaluation of WHO's contribution in Namibia including: (a) describing the relationship between the priorities of the CCS, the focus areas, and the interventions and budgets as envisaged in the biennial Country Office work plans; (b) clarifying the linkages with the WHO General Programme of Work and programme budgets; (c) describing how WHO secretariat outputs and outcome areas would be expected to contribute to Namibia health outcomes and impact; and (d) identifying the main assumptions underlying it.
- Develop and apply an evaluation matrix geared towards addressing the key evaluation questions, considering the data availability challenges, the budget, and timing constraints.
- Follow the principles outlined in the WHO Evaluation Practice Handbook, and the United Nations Evaluation Group (UNEG) norms and standards for evaluation and its ethical guidelines.
- Adhere to WHO cross-cutting strategies on gender equality, equity, human rights, disability inclusion and include to the extent possible disaggregated data and information as well as gender- and disability-sensitive and human rights-informed approaches for data collection. This evaluation will adhere to the UNEG norms and standards for evaluation *(12)* and WHO guidance and policies, including the WHO Policy and Strategy on Health Equity, Gender Equality and Human Rights, 2023—2030 *(13)*; the WHO Policy on Disability *(14)*; the WHO Evaluation Policy *(1)*, UNEG guidance on integrating human rights and gender equality in evaluations *(15, 16)* and UNEG guidance on integrating disability inclusion in evaluations *(17)*. The evaluation is expected to integrate gender, equity, and human rights considerations in its conceptualization, design, and analysis, ensuring that principles of 'leave no-one behind' and 'do no harm' are duly considered. This involves analysis of the inclusion of human rights principles and alignment with the SDGs as applicable to the object of the evaluation, as well as appropriate ethical approaches and risk assessments in the design and execution of the evaluation.
- Include ethical considerations as highlighted in the 'ethical considerations' section below. The methodology should demonstrate impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups) and using a mixed methodological approach to ensure the triangulation of information through a variety of means.

The evaluation of WHO's contribution in Namibia will rely mostly on the following mixed data collection methods:

- **Document review**. This will include a wide range of key strategic documents, including but not limited to general programmes of work; relevant Country Office programme budget and work plans; budget, financial, audit, and closure reports; Country Office annual reports, country-level adaptations of WHO technical products; and relevant national policies and strategies. Relevant reports at the Regional and Country Office levels will be identified and reviewed.
- **Quantitative data** from the Country Office monitoring system to assess progress against key health indicators.
- **Stakeholder interviews** will be conducted with both external and internal stakeholders as detailed below.
- **In-country mission**. Following the document reviews and initial stakeholder interviews, the two-week visit in country will give the evaluation team the opportunity to develop an in-depth understanding of the perspectives of the various stakeholders around the evaluation questions and collect additional secondary data, in particular from external stakeholders and health service providers. Field visits at the regional level will be arranged if deemed useful.
- **Stakeholders' consultation**. In addition to acting as key informants during the evaluation process, key internal and external stakeholders will be consulted during the drafting stages of the terms of reference, inception report, and evaluation report, and will have the opportunity to provide comments.
- **Validation workshop**

10. Stakeholders

Internal stakeholders include the relevant WHO staff at the Country Office, Regional Office and headquarters. Other stakeholders include but are not limited to officials from the Ministry of Health and Social Services and other relevant Government institutions; healthcare professional associations and other relevant professional bodies; relevant academic and research institutes, agencies and academia; UN agencies (UNICEF, UN Women, UNFPA, UNDP, UNAIDS); bilateral partners and donor agencies (Japan, USAID); and non-State actors and civil society.

11. Ethical considerations

Due diligence will be given to effectively integrating good ethical practices and paying due attention to robust ethical considerations in conducting the evaluation of WHO's contribution in Namibia. Confidentiality and anonymity, do-no-harm approaches, the use of the appropriate ethical protocols, and inclusion of gender equality and human rights consideration will be ensured in the way data is collected, stored, analysed, and reported. Any WHO-conducted event, including an evaluation process, is expected to take note of the Organization's standards of conduct, especially the requirements in the Code of Conduct to Prevent Harassment, Including Sexual Harassment, at WHO Events (18), and the WHO Policy on Preventing and Addressing Sexual Misconduct (19) apply. WHO has zero tolerance for any form of sexual misconduct and for inaction against it.

12. Evaluation phases, timelines, and deliverables

The evaluation is structured around five phases summarized in Table A1.4:

Table A1.4. Evaluation phases

Phase	Timeline	Tasks and deliverables
1. Preparation	October 2024	Scoping Terms of reference developed Evaluation team constituted
2. Inception	November 2024	Document review and inception interviews Final inception report, WHO Quality Assurance
3. Data collection and analysis	Mid November 2024	Country Office, Regional Office, and headquarters briefings Interviews, country visit, data analysis
4. Validation and finalization	February	Draft evaluation report, WHO Quality Assurance Validation workshop (virtual) Final evaluation report, evaluation brief, WHO Quality Assurance
5. Dissemination and learning	From March 2024	Management response Dissemination via publication and workshops

12.1 Inception phase: Inception report as the first deliverable

The inception phase will start with a first review of key documents and briefings with headquarters, Regional Office, and Country Office key stakeholders. During the design phase, the evaluation team will assess the various logical results frameworks, if they exist, and their underlying theory of change. The inception report will close this phase. Its draft will be shared with key internal stakeholders at all three Organization levels for their feedback. The inception report will be prepared following the Evaluation Office template and will focus on methodological and planning elements. It will present an evaluation matrix. Data collection tools and approaches will be drafted as part of the inception report, alongside consent forms and ethical protocols.

12.2 Data collection and analysis phase

This phase will include additional document review, key stakeholder interviews at headquarters and regional levels, and a country visit. The in-country mission in Namibia will start with briefings to the Country Office and key partners and will end with a debriefing with the same group at the end of the mission. During inception, the Country Office will advise the evaluation team as to possible locations for field work, if required. As the WHO evaluation function is independent of the WHO program planning and implementation function, the WHO Evaluation Office at the headquarters or regional office may join the in-country data collection mission alongside the evaluation team and complement the data collection exercise.

12.3 Validation phase: Draft Evaluation Report as the second deliverable

This phase will involve in-depth organization of key findings and results, and identification of key lessons learned and recommendations. These will be presented in the draft evaluation report, which will be shared with key internal and external stakeholders, the Evaluation Management Group, and the Evaluation Reference Group for fact-checking. To ensure the credibility and validity of evaluation findings, evaluators will triangulate emerging evidence. Evaluation evidence collected from different sources or by different methods will be compared to ensure that the data is valid, and that conclusions and recommendations are solely derived from evidence.

Validation workshop: Initial findings will be presented to stakeholders (the Country Office and the Evaluation Reference Group) in a virtual workshop at the end of the in-country visit to assess the validity and accuracy of the findings and their relevance to the Namibia context and programmes. During the workshop, stakeholders will be invited to help the evaluators identify and prioritize recommendations that should directly inform the development of the next CCS. The feedback will be documented, including where any divergent views arise from the findings. As far as possible, the conclusions will be based on triangulated evidence.

Before the finalization of the recommendations, the WHO Representative, in collaboration with the Regional and headquarters office evaluation teams, will organize a high-level stakeholder workshop with the main counterparts in-country to discuss the findings, conclusions, and recommendations of the evaluation team. Recommendations should directly inform the development of the new CCS. A draft management response could also be presented at the workshop to ensure buy-in and commitment for all parties.

12.4 Finalization phase: Final evaluation report with an evaluation brief as the third deliverable

A final evaluation report and a 2—3-page evaluation brief will be prepared according to the WHO Evaluation Practice Handbook. The evaluation report, executive summary, and brief will provide an assessment of the results according to the evaluation questions and methodology identified above. It will include conclusions based on the evidence generated in the findings and draw actionable recommendations. Evaluators are encouraged to use varied visualization approaches in the report, such as infographics and visual summaries. Where figures, tables, charts, or any infographics are used in the final report, the evaluator should ensure they are editable.

12.5 Management response and dissemination of results phase

The management response will be prepared by the Namibia WHO Representative (while consulting with the Regional Office and headquarters as appropriate based on the areas recommended) before the finalization of the evaluation report. To ensure transparency as envisaged in the WHO Evaluation Policy and the UNEG norms and standards for evaluation, the reports of evaluations of WHO's contribution at the country level and their management responses will be made publicly available and

summaries will be reported in the annual evaluation report to the WHO Executive Board. Further dissemination may be conducted through the country and regional office workshops.

13. Evaluation team

The evaluation will be conducted by a team of two experienced consultants with complementary skills and expertise in evaluation and public health, as follows:

13.1 Senior Evaluation Specialist:

The Senior Evaluation Specialist will ensure quality assurance is embedded throughout the evaluation process and on the evaluation deliverables, including adhering to WHO evaluation quality assurance checklist standards[11].

The Specialist should demonstrate the following:

- Relevant professional qualification, preferably at the master's or doctorate level;
- At least 15 years of experience in conducting evaluations preferably in the areas of public;
- health, health economics, or development, and experience in country-level strategic or programme evaluations, with a focus on Sub Saharan Africa;
- Demonstrated knowledge of public health, emergency response, health systems strengthening, and PHC;
- Proven experience in conducting participatory and utilization-focused evaluations, qualitative and quantitative data collection methods, analysis of data, and experience in handling data limitations;
- Experience evaluating incorporation of health equity, gender equality, human rights, and other equity issues in programmes;
- Appropriate evaluation knowledge and skills and relevant experience in performing similar evaluations involving organizational assessments in multilateral or United Nations organizations;
- Strong interpersonal skills and ability to work with people from different backgrounds to
- deliver high-quality products within a short period; and
- Excellent writing, analytical, and communication skills in English.

13.2 Senior Public Health Consultant

The Senior Public Health Consultant will contribute to the evaluation design, data collection at the country level, analysis, and report writing. The Consultant should demonstrate the following skills:

- A university degree at master's level in public health, health economics and related areas, social science, or political science;
- At least five years of experience in conducting evaluations in the areas of public health, economics, or development, and experience in country-level strategic evaluations;
- Knowledge and experience of the health and development sector in Sub-Saharan Africa, with knowledge of the Namibia health system as an added advantage;
- Strong interpersonal skills and the ability to work with people from different backgrounds; and

[11] Will be shared with the evaluation team during inception

- Excellent analytical and communication skills in English.

Desirable:

- A doctorate-level university degree in public health, health policy, health economics, health systems, public policy, strategic planning;
- At least ten years of experience in the review and development of organizational strategy;
- Specific experience in facilitating meetings, consultations, assessments within the health and development sector; and
- Experience working with UN agencies.

13.3 Deliverables of the consultancy

1. An evaluation report
2. A two-page brief highlighting key findings and recommendations
3. A power point presentation, no more than 15 slides.

14. Evaluation management

To ensure the independence and credibility of the evaluation, this evaluation will be conducted by an external independent evaluation team and managed by the Regional Office in collaboration with the WHO Evaluation Office.

The Regional Evaluation Officer will serve as the Evaluation Manager and will provide the necessary support to the evaluation team during the evaluation exercise (such as finalizing the methodology, facilitating the evaluation process, and identifying relevant documents and stakeholders).

The WHO Country Office in Namibia will nominate an Evaluation Focal Point, who will facilitate the coordination of evaluation activities at the country level including reviewing and contributing to terms of reference and key deliverables, facilitating access to data and relevant documents promptly, and providing logistical support during the in-country mission.

The evaluation team will hold regular progress meetings with the Evaluation Manager and Evaluation Focal Point, and where required, may invite the Evaluation Management Group to join in some sessions as appropriate. The headquarters Evaluation Office will be part of the Evaluation Management Group and will support the regional office in the management of the evaluation, where needed.

Additionally, the headquarters Evaluation Office will provide overall quality assurance for both the process and products of the evaluation in adherence with United Nations Evaluation Group (UNEG) norms and standards.

An Evaluation Reference Group will be established to ensure the evaluation’s relevance, accuracy, and utility through a consultation and validation process. The Evaluation Reference Group will include relevant staff from Regional Office and the Country Office, representatives from the Ministry of Health and Social Services, implementing partners, and UN agencies in Namibia with whom the Country Office has worked closely over the period under evaluation. The Evaluation Reference Group will review the key evaluation deliverables (the terms of reference, inception report, and the draft and final reports), including the validation of the technical findings.

Appendix A: Performance across 2018-2023 CCS objectives[12]

Advancing UHC

- Improvement in access to essential health services in the country although 24% of the population still live beyond the recommended 10KM radius to a health facility.
- Epidemiological transition from predominantly communicable diseases to a mix of communicable diseases, NCDs, and trauma and injuries.
- Constrained health sector fiscal space characterized by a reduction in donor support and a slowdown in national economic growth.

Addressing health emergencies

- Functional disease surveillance and response systems at national level, although this needs strengthening at the subnational level.
- The National Public Health Institute has yet to be established.
- Border points and ports of entry surveillance sites are in place.
- The country is meeting its IHR commitments.

Promoting healthier populations

- Health education activities for creating awareness on healthy diets and importance of physical activities have yet to be realized.
- Good progress has been made in promotion of SRH and prevention of gender-based violence.
- Intersectoral collaboration for incorporating Health in all policies and address social determinants of health has yet to be realized.
- Progress has been made in taming the problem of drug and alcohol abuse.

Strengthening leadership, governance and enabling functions

- Health facility reporting rates improved from 85% in 2016 to 88% in 2020.
- Interoperability and integration of systems recorded slow progress. Data systems were fragmented.
- HIS human resource capacity in the country is low to carry the workload across various levels of the system.
- Generally slow progress in the development and implementation of policies.

[12] Draft Country Cooperation Strategy III 2018 – 2022: Accelerating Progress Toward Universal Health Coverage. End Term Review Report. Windhoek: WHO Country Office, Namibia; May 2022.

Appendix B: Performance indicators

Table A1.B.1 provides a summary of the performance of all the indicators identified in the results framework of the CCS.

Table A1.B.1: Composite indicators of the CCS results framework

Indicator	Baseline 2018	Target	Achievement	Performance (%)	Disaggregation factors	Indicator alignment
Strategic priority 1: Advancing UHC						
Number of human resources for health per 1000 population	3.6	4.45	4.45[a]	100	Geo/socio-economic status, private/public	GPW, NHSSP
Maternal mortality rate per 100 000 live births	265	200	195[b]	135.9	Age, geo/socio-economic status	GPW, UNPAF, NHSSP
Neonatal mortality rate per 1000 population	39	20	39.9[c]	50.1	Geo/socio-economic status	GPW, UNPAF, NHSSP
Percent of women of reproductive age (15-49) who have their need for family planning satisfied with modern methods	80	90	80.4[d]	89.3	Age, geo/socio-economic status	GPW, UNPAF, NHSSP
Percent of measles vaccination coverage	79	90	80[e]	88.9	Age, geo/socio-economic status	GPW, NHSSP
Number of malaria deaths	120	50	51[f]	98	Age, geo/socio-economic status	GPW, NHSSP
Number of new HIV infections per 1000 population	4.3	0.9	2.92[g]	30.8	Age, geo/socio-economic status	GPW, UNPAF, NHSSP
Percent of RR-TB treatment coverage	60	71	65[h]	91.5	Age, geo/socio-economic status	GPW, NHSSP
Percent of premature NCD-related mortality	43	35	54.1[i]	64.7	Age, geo/socio-economic status	GPW, UNPAF, NHSSP
Percent of people suffering financial hardship in accessing health services	<1	<1	—	—	Age, geo/socio-economic status	GPW, UNPAF, NHSSP
Total Score				**66.7**		
Strategic priority 2: Addressing health emergencies						
Percent of core surveillance and response capacity requirements for IHR met	<10	50% increase	61[j]	122	Age, geo/socio-economic status	GPW, NHSSP
Percent of suspected outbreaks investigated in time and contained	67	100	—	—	Age, geo/socio-economic status	GPW, NHSSP
Total Score				**100**		

Strategic priority 3: Promoting healthier populations						
Percent of stunted children under 5	24%	14%	22.7% (NDHS 2013)	61.7%	Age, geo/socio-economic status	GPW, UNPAF, NHSSP
Percent of urban households using improved sources of water	98.3	100	96[k]	96	Age, geo/socio-economic status	GPW, NHSSP
Percent of households using improved toilet facilities not shared with other households	Urban 77 Rural 28	Urban 87 Rural 40	Urban[k] 50 Rural 20	Urban 57.4 Rural 50	Geo/socio-economic status	GPW, UNPAF,
Percent of men (15-49 years) using tobacco	19	—	28.4[l]	—	Age, geo/socio-economic status	Age Geo /Socioeconomic status GPW, NHSSP
Suicide mortality rate per 100 000	22.1	—	9.7[m]	—	Age, geo/socio-economic status	GPW, NHSSP
Prevalence (%) of obesity in women (35-64 years)	32	—	28.9[n]	—	Age, geo/socio-economic status	GPW, NHSSP
Total Score				**46.7%**		
Overall Score				**66.7%**		

Key:

Green	**Good progress**	**Yellow**	**Moderate progress**	**Red**	**No progress or deterioration**	**Grey**	**No data**

Indicators with no data are not included in the overall score.

[a] Source: (2022)
[b] Source: (2017, WHO, GHO)
[c] Source: (2020, WHO GHO)
[d] Source: (2013, WHO GHO)
[e] Source: (2019, WHO GHO)
[f] Source: (2020, World Malaria Report)
[g] Source: (2020, HIV Estimates)
[h] Source: (2020, The Ministry of Health and Social Services program report)
[i] Source: (2020, WHO GHO)
[j] Source: (2020 WHO GHO)
[k] Source: SDG6 data *(20).*
[l] Source: (2018, WHO GHO)
[m] Source: (2019, WHO GHO)
[n] Source: Global Nutrition Report *(21)*.

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Annex 2. Evaluation matrix

Key evaluation questions and sub-questions	What will be assessed or measured	Data sources	Data collection methods
Key evaluation question 1. To what extent are the Country Office's positioning, level of engagement, and interventions aligned to the national context and the evolving needs, policies, and priorities of the government, and to the needs and rights of Namibians? (Relevance)			
1.1 To what extent are the Country Office's support and interventions aligned to the national policies and priorities and evolving health needs and development priorities of Namibia?	CCS reflects priorities of national health policies and strategies National health planning or strategy documents mention WHO Evidence of WHO review and adjustment to interventions in response to changes in country context and emerging needs	National Development Plan National health strategy CCS III Biennial Plans and reports WHO emergency plans	Key informant interviews with WHO, Government, and other external stakeholders Document review
Key evaluation question 2. To what extent have WHO interventions and implementation approaches integrated and demonstrated synergies and complementarity with one another as well as with interventions carried out by the government and other partners in Namibia?			
2.1 To what extent are Country Office interventions and implementation approaches integrated and synergized internally, and complementary to the Government's and partners' interventions?	Examples of collaboration across CCS III strategic pillars Map development partner country or sector strategies to identify opportunities for collaboration and leveraging resources Evidence of how well WHO leveraged the Development Partners Forum	CCS III Biennial plans and reports Development partner country strategies Minutes and reports of Health Development Partners Forum	Key informant interviews with WHO, Government and development partners Document review
2.2 How has WHO harnessed its comparative advantage, particularly in its role as a convening and coordinating partner and health leader, to deliver on its mandate?	WHO use of convening power, technical expertise, and coordination function WHO leadership role on health in the UN Country Team Documented evidence of how well WHO coordinated health sector development partners WHO contribution to the UN Country Team, thematic groups, and results groups	UN annual reports on UNPAF Documents on UNPAF thematic groups and results groups Minutes and reports of Health Development Partners Forum	Key informant interviews with WHO, Government, UN agencies, development partners, and other stakeholders Document review
Key evaluation question 3. To what extent were WHO results (including contributions at the outcome and system level) achieved or are likely to be achieved and what factors influenced (or did not influence) their achievement? (Effectiveness, efficiency)			

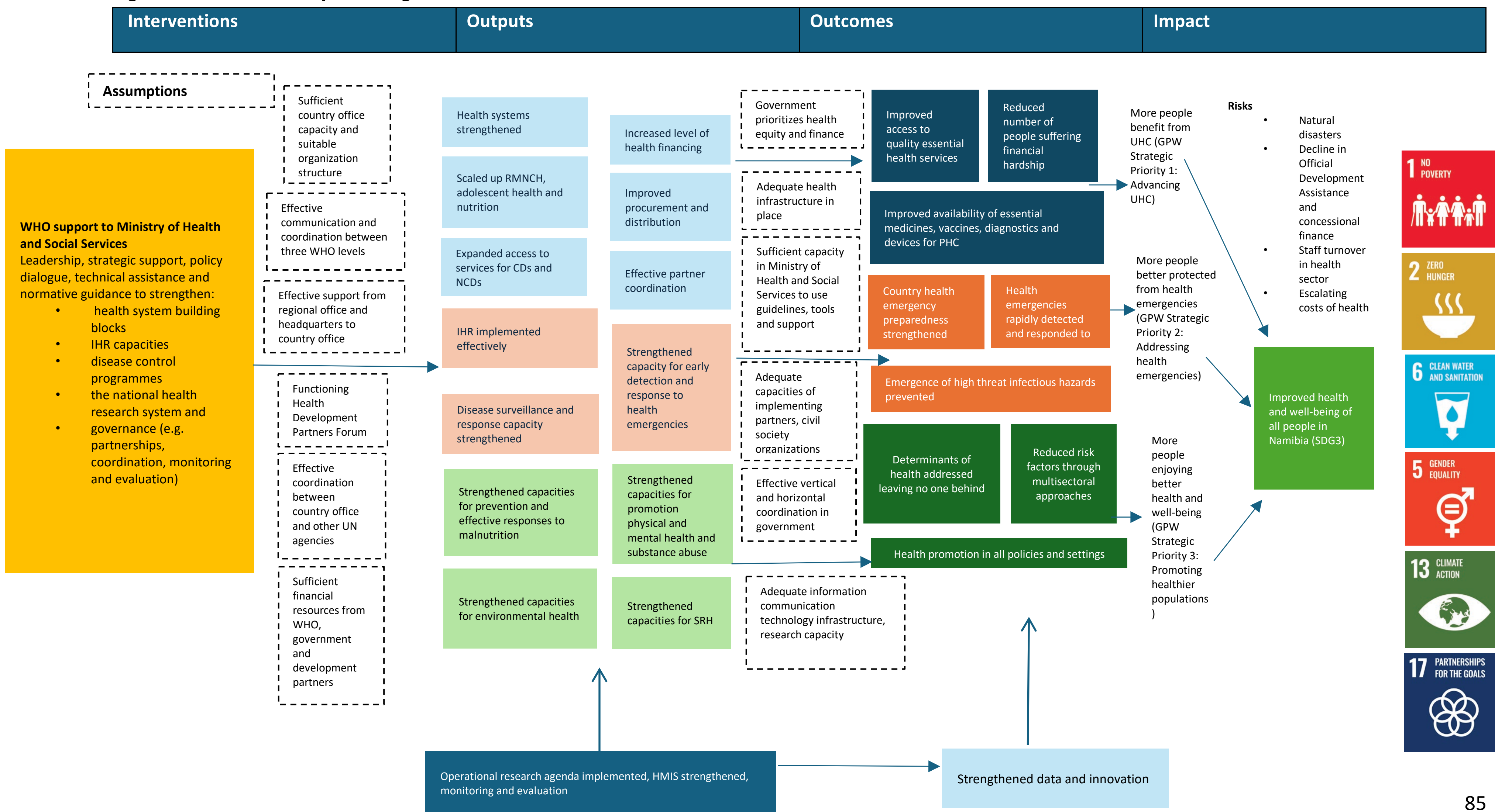
3.1 What were WHO's key achievements during the period of the CCS? What factors explain the attainment (or lack thereof) of planned CCS objectives? What challenges were faced in implementing the current CCS?	Assess planned results against actual results achieved for evidence of progress in outcome indicators Identify enablers and constraints, such as adequacy of financial and human resources of WHO, Government and partners Capacity in the Ministry of Health and Social Services to use guidelines, tools and support Adequacy of health infrastructure, including information and communication technology Government prioritization of health equity and finance Strength of the Ministry of Health and Social Services coordination from national to regional and local levels and coordination with other ministries	Country Office annual reports Ministry of Health and Social Services annual reports Databases: National Health Management Information System WHO Global Health Observatory Evaluation reports or assessment of specific interventions	Key informant interviews with WHO, Government, UN agencies, development partners and other stakeholders Focus group discussions with Country Office staff Document review (including database searches)
3.2 How effective was WHO's country-level COVID-19 response in supporting national health systems in managing the pandemic? Were there any best practices, innovations, or lessons learned from WHO's interventions in Namibia during the COVID-19 response? How can these insights inform future WHO interventions and specifically strengthen pandemic preparedness and response in Namibia?	Views of WHO, the UN Country Team, the Ministry of Health and Social Services, development partners and stakeholders on WHO response Documented examples of WHO technical contribution to government response	Ministry of Health and Social Services reports UN Namibia COVID-19 response reports and socio-economic impact reports Reports from nongovernmental organizations and development partners	Key informant interviews with WHO, Government, UN agencies, development partners and other stakeholders Document review
3.3 What has been the added value of WHO Regional Office and headquarters contributions to the achievement of results in Namibia?	Opinions about Country Office, Regional Office and headquarters on contributions to achievements Assess communication and coordination of the three WHO levels, and the structures or mechanisms in place to facilitate communication and coordination	Country Office and Regional Office reports	Key informant interviews at the Regional Office and headquarters

	Assess the extent to which the Regional Office and headquarters responded to specific needs of the Country Office The timeliness of Regional Office and headquarters contributions		
3.4 To what extent is the current human resource complement fit for the level of health system of the country and the required technical assistance?	Assess structures and human resources against factors, such as the technical capacity to respond to the scale of Ministry of Health and Social Services needs Country Office internal coordination, organizational flexibility and adaptability to changing circumstances Capacity for leadership in UNPAF on health matters Capacity to plan, implement with minimal delays, monitor and report.	Country Office and Regional Office reports Corporate reports on human resources Audit reports	Key informant interviews with WHO, Government and other external stakeholders Focus group discussions with Country Office staff
3.5 To what extent were the required financial resources mobilized and allocated efficiently to implement CCS priority interventions smoothly?	Resources directed according to plan but with sufficient flexibility to redirect resources to respond to urgent health needs and additional requests from the Ministry of Health and Social Services Success in mobilizing resources from development partners	Financial reports Audit reports Country Office annual reports	Key informant interviews with WHO, Government and other external stakeholders Focus group discussions with Country Office staff
Key evaluation question 4. To what extent has WHO contributed towards building sustainable national capacity of institutions and relevant government structures to lead the health development agenda? (Sustainability)			
4.1 To what extent have WHO interventions supported national ownership for health system strengthening, as well as the national capacity to deliver on and achieve the results as planned in the relevant national health policies and strategies? Is there evidence that the benefits will be sustained over time?	Mechanisms in place to support national ownership, interventions with clear exit strategies, use of national systems Evidence that systems and tools can be used without further support from WHO	Evaluations of Country Office interventions Country Office annual reports	Key informant interviews WHO, government and other external stakeholders Focus group discussions with Country Office staff
4.2 What are the key lessons learned and unfinished agenda for consideration in the next five-year strategy?	Lessons for CCS design, implementation, monitoring and reporting Unfinished agenda (link to sub-question 3.1)	Evaluations of Country Office interventions Country Office annual reports	Key informant interviews with WHO, Government and other external stakeholders

			Focus group discussions with Country Office staff
Key evaluation question 5. To what extent did WHO address the needs and rights of vulnerable populations, especially those at risk of being the furthest left behind?			
5.1 To what extent did Country Office support and interventions consider the needs and rights of vulnerable populations, including women, children, older persons, persons with disabilities, the poor, persons with disabilities, people living with HIV, groups in remote areas, and migratory groups?	Gender and inclusion mainstreaming into Country Office support and interventions Evidence of targeting and prioritising the most vulnerable populations and marginalized groups in Country Office support and interventions Evidence of capacity building of health service users and their understanding their rights and the capacity of health service providers to meet their obligations	CCS III Biennial Plans Country Office annual reports Ministry of Health and Social Services reports Patient charter	Key informant interviews with WHO, UN agencies, Government and development partners

Annex 3: Draft theory of change

Figure A4.1 Draft theory of change



1. Theory of change narrative

WHO contribution in Namibia has the long-term goal of contributing to improved health and well-being of all people in Namibia (SDG 3) and contributing to the related SDGs 1, 2, 5, 6, 13 and 17. Working from left to right:

A) **IF** WHO (Country Office, Regional Office, headquarters) provides leadership, policy dialogue, strategic support, technical assistance, and public goods (normative guidance, data, research and innovation) to the Government of Namibia (the Ministry of Health and Social Services and other relevant sectors) for strengthening systemic capacities in areas including building and coordinating partnerships; building the national health research system to produce, translate, disseminate, and use knowledge in policy, planning, and product and service development; developing and applying norms, standards, and guidelines; monitoring the health situation and assessing health trends; and building resilient national health system capacities,

THEN health systems will be strengthened, RMNCH, adolescent health, and nutrition services will be scaled up; there will be expanded access to services for communicable and non-communicable diseases; the level of health financing will be increased; procurement and distribution of health equipment and products will improve; and partner coordination will be more effective (Outputs); and

IF these outputs are achieved, **THEN** people will have improved access to essential health (Outcome 1.1); there will be improved availability of essential medicines, vaccines, diagnostic and devices for PHC (Outcome 1.2); and a reduced number of people will suffer financial hardship due to health costs (Outcome 1.3); and

IF these outcomes are achieved, **THEN** more people will benefit from UHC (GPW Strategic priority 1).

B) **IF** WHO provides institutional capacity strengthening support to the Ministry of Health and Social Services in areas including IHR, surveillance, and emergencies,

THEN IHR will be implemented effectively, and disease surveillance and response capacity and early detection and response to health emergencies will be strengthened (Outputs); and

IF these outputs are achieved, **THEN** Namibia's health emergency preparedness will be strengthened (Outcome 2.1), health emergencies will be rapidly detected and responded to (Outcome 2.2), and emergence of high-threat infectious hazards will be prevented (Outcome 2.3); and

IF these outcomes are achieved, **THEN** more people will be better protected from health emergencies (GPW strategic priority 2).

C) **IF** WHO provides institutional capacity strengthening support to the Ministry of Health and Social Services in areas including nutrition, environmental health, SRH, and health promotion,

THEN capacities for prevention and effective responses to malnutrition, environmental health, SRH and health promotion (physical and mental health, substance abuse) will be strengthened (Outputs); and

IF these outputs are achieved, **THEN** social determinants of health will be addressed (Outcome 3.1), multisectoral approaches will reduce health risk factors (Outcome 3.2), and health promotion will be mainstreamed in all policies and settings (Outcome 3.3); and

IF these outcomes are achieved, **THEN** more people will enjoy better health and well-being (GPW strategic priority 3).

The theory of change includes an outcome of strengthened data and innovation (Outcome 4.1) that contributes to the outcomes related to the three strategic priorities.

2. Assumptions and risks

The theory of change identifies assumptions—positive conditions that must be in place in order to achieve the outputs and outcomes. These assumptions include factors, such as the Government's commitment to prioritizing health equity, the adequacy of health and information and communication technology infrastructure, and the absorptive capacity of the Ministry of Health and Social Services. Risks include the decline in development assistance and concessional finance, staff turnover, and the escalating cost of health care. By making these assumptions explicit, the evaluation team was able to identify issues for close examination and ensure their inclusion in the data collection tools.

Table A4.1: Linking evaluation questions to the draft theory of change

Evaluation question	Theory of change element that will be considered in answering the evaluation question
Key evaluation question 1. To what extent are the Country Office's positioning, level of engagement, and interventions aligned to the national context and the evolving needs, policies, and priorities of the government, and to the needs and rights of Namibians? (Relevance)	Interventions supported by WHO (Inputs)
Key evaluation question 2. To what extent have WHO interventions and implementation approaches integrated and demonstrated synergies and complementarity with one another as well as with interventions carried out by the Government and other partners in Namibia? (Coherence)	Assumptions: • Effective support from the Regional Office and headquarters to the Country Office • Effective communication between the three WHO levels • Effective coordination between the Country Office and other UN agencies • Functioning Health Partners Development Forum

Key evaluation question 3. To what extent were WHO results (including contributions at the outcome and system level) achieved or are likely to be achieved and what factors influenced (or did not influence) their achievement? (Effectiveness, efficiency)	Pathway from interventions to outputs (Assumptions) • Effective support from the Regional Office and headquarters to the Country Office • Effective communication between the three WHO levels • Effective coordination between the Country Office and other UN agencies • Functioning Health Partners Development Forum • Sufficient Country Office capacity and suitable organization structure • Sufficient financial resources from WHO, Government, and development partners
Key evaluation question 4. To what extent has WHO contributed towards building sustainable national capacity of institutions and relevant government structures to lead the health development agenda? (Sustainability)	Pathway from outputs to outcomes (Assumptions) • Government prioritizes health equity and finance • Adequate health infrastructure in place • Sufficient capacity in the Ministry of Health and Social Services at all levels to use guidelines, tools and support • Adequate capacities of implementing partners and civil society organizations • Effective vertical and horizontal coordination in Government • Adequate information and communication technology infrastructure, research capacity

Annex 4: Key informants by category and gender

Key informants	Number of interviews	Number of persons	Number of females	Female informants (%)
WHO Country Office in Namibia	7	13	10	77
WHO Regional Office for Africa clusters	7	15	6	40
WHO headquarters	4	10	4	40
Ministry of Health and Social Services	7	15	7	47
Opuwo District Hospital	1	3	2	66
Kunene Regional Headquarters of the Ministry of Health and Social Services	1	5	3	
Ministry of Education, Arts and Culture	1	1	0	0
Ministry of Gender Equality, Poverty Eradication and Social Welfare	1	2	2	100
National Road Safety Council	1	1	0	0
United Nations Country Team (UN Resident Coordinator. FAO, United Nations Development Programme, UNICEF, UNFPA, UNAIDS, World Food Programme)	7	8	7	87.5
Development partners (USAID, US Centers for Disease Control and Prevention)	2	2	1	50
UNAM Faculty of Health Science	1	2	1	50
Civil society organizations, nongovernmental organizations	2	2	1	50
Total	32	55	44	80

Annex 5: Data collection tools

1. Generic key informant interview

Generic key informants interview guide—to be adapted for different stakeholder categories

- Introductions
- Purpose of evaluation
- Confidentiality and anonymity
- Consent

Name and position:
Date:

Introduction Briefly describe your role in your organization and your involvement in WHO work in Namibia.
Relevance questions
1. To what extent is WHO addressing the most important health priorities of Namibia?
2. To what extent is WHO integrating the inclusion of vulnerable groups into its programmes? - poor people, people in rural areas, women, older persons, persons with disabilities, adolescents and youth
Coherence questions
3. (WHO only) Has the Country Office taken deliberate action to build synergies across the strategic priorities? (Give an example.)
4. (WHO and UN agencies only) What were WHO's roles, contributions, and effectiveness in developing, monitoring and evaluating the UNPAF?
5. How well does WHO make use of its relationship with the Government for advocacy on difficult or politically sensitive issues in the health sector?
6. How well does WHO coordinate actors and stakeholders in Namibia's health sector? Has WHO promoted effective partnerships in the health sector?
Effectiveness questions
7. What do you consider as the key contributions of WHO to the achievement of Namibia's health development agenda since 2018? (For the Country Office, question per CCSIII strategic priority or pillar.)
8. To what extent did WHO's country-level COVID-19 response effectively support national health systems in managing the pandemic?
9. What factors enabled the achievement of results?
10. What challenges were experienced in the implementation of WHO support and interventions?
11. (WHO only) How did the Regional Office and headquarters contribute to achievement of results in Namibia? Provide examples of their contributions.
Efficiency questions
12. Is the Country Office structured and staffed appropriately to perform its functions?
13. How successful was the Country Office in mobilizing financial resources? Were financial resources allocated realistically for achieving the intended results of interventions?
Sustainability questions
14. What is the likelihood that results achieved will be sustained over the medium-to-long term? Give reasons for your response.
15. What actions are Government partners, in particular the Ministry of Health and Social Services, taking sustain what has been achieved?
16. What actions has the Country Office taken to ensure the sustainability of results achieved?
Looking ahead
17. What is the unfinished agenda from the current CCS that should be taken forward into the next strategy?
18. What lessons have been learned (positive and negative) from the implementation of the current CCS?

2. Preparatory questions for WHO Country Office pillars

Each pillar is requested to prepare a presentation covering the following five questions. The evaluation team will follow up with specific questions for each pillar.

1. Provide a brief description of the pillar or programmes.

2. Outline the results achieved between 2022 and present (if able to go back to 2018, please do so).

3. What enabled the achievements of the pillar or programme?

4. What challenges were experienced or are being experienced in implementation?

5. What suggestions or proposals do you have for improvement?

3. Preparatory questions for Regional Office clusters

Please answer the following questions, providing examples where possible, thinking of your contributions to WHO Country Office in Namibia from 2018 through 2024.

1. What is your Cluster and its functions?

2. Can you please describe the key Regional Office Cluster programmes, strategies, or interventions that have been implemented in support to countries?

3. What were the key support interventions or activities from the Regional Office to the Country Office?

4. What do you consider to have been the key health-related changes in Namibia that WHO has contributed to?

5. What have been key challenges and setbacks in supporting countries such as Namibia?

6. What was done specifically by WHO in Namibia to reduce health inequities, address needs of the vulnerable, and promote gender equality?

7. What are your recommendations for increasing financial resource mobilization for Namibia given the limited number of in-country development partners?

8. What are the key priorities, related to your Cluster, that the Country Office should focus on in the upcoming CCSIV, starting in 2025?

4. Questions for the Ministry of Health and social services (and other government ministries)

1. Briefly describe your role in the Ministry, what your directorate or division does, and your involvement in WHO work in Namibia.
2. In your view, is WHO addressing the most important health priorities of Namibia? Are there critical areas that WHO is not addressing?
3. What support has your directorate or division received from WHO between 2018 and the present?
4. How helpful has the support been to your directorate or division?
5. How well does WHO coordinate partners in the health sector?
6. What do you consider as the key contributions of WHO to Namibia's health agenda since 2018?
7. What can WHO improve or do differently in its next country cooperation strategy?
8. What areas could WHO support your division with the next cooperation strategy?
9. Do you have any other comments?

5. Questions for United Nations agencies

1. To what extent is WHO addressing the most important health priorities of Namibia?
2. To what extent is WHO integrating the inclusion of vulnerable groups into its programmes?
3. What were WHO's roles, contributions, and effectiveness in developing, monitoring and evaluating the UNPAF?
4. Provide example(s) of collaboration between your agency and WHO. How effective was the collaboration?
5. How well does WHO make use of its relationship with the Government for advocacy on difficult or politically sensitive issues in the health sector?

6. How well does WHO coordinate the actors and stakeholders in Namibia's health sector? Has WHO promoted effective partnerships in the health sector?

7. What do you consider as the key contributions of WHO to the achievement of Namibia's health development agenda since 2018?

8. What is the likelihood that results achieved will be sustained over the medium-to-long term? Give reasons for your response.

9. What is the unfinished agenda from the current Country Cooperation Strategy that should be taken forward into the next strategy?

10. What can WHO improve or do differently in the next Country Cooperation Strategy?

6. Questions for civil society organizations

1. Briefly describe your role in your organization, what your organization does, and your involvement in WHO work in Namibia.

2. In your view, is WHO addressing the most important health priorities of Namibia? Are there critical areas that WHO is not addressing?

3. Provide example(s) of collaboration between your organization and WHO. How effective was the collaboration?

4. How well does WHO coordinate partners in the health sector?

5. What do you consider as the key contributions of WHO to Namibia's health agenda since 2018?

6. What can WHO improve or do differently in its next country programme?

7. Are there areas that civil society organizations or nongovernmental organizations and WHO can collaborate on in the new WHO Namibia Cooperation Strategy for 2025-2030?

7. Points for discussion with health staff in the region and district hospital

1. The health profile and health needs of the region (and district if possible)
2. The key challenges the region (and district hospital) face in delivering health services
3. The role and functions of the region and how the region interacts with the national ministry and
4. the local level of the health system
5. What support the region and district hospital have received from WHO
6. What the region and district hospital are able to do better since they received WHO support.
7. Things WHO can do differently or better
8. New or emerging issues that WHO should pay attention to in the future

8. Financial information tool

Tool: Final evaluation of WHO CCS for Namibia (2018—2024): Financial information						
CCS III strategic priorities	**Focus Area**	**2018—2019, 2020—2021, 2022—2023, 2024**				Comments
		Workplan funding (US$)	Amount budgeted (US$)	Expenditure and encumbrances (US$)	Implementation Rate (%)	
Strategic priority 1: Advancing UHC	**1.1.1**					
	1.1.2					
	1.1.3					
	1.2.1					
	1.2.2					
	1.2.3					
	1.3.1					
	1.3.2					
Strategic priority 2: Addressing emergencies	**2.1.1**					
	2.2.1					
	2.3.1					
	2.3.2					
Strategic priority 3: Promoting healthier populations	**3.1.1**					
	3.1.2					
	3.1.3					
	3.2.1					
	3.2.2					
	3.2.3					
	3.3.1					
	3.3.2					
Strategic priority 4: Strengthening leadership, governance, and enabling functions	**4.1.1**					
	4.1.2					
	4.1.3					
Total						

Note: Would you kindly provide the above information per biennium to us?

9. Status of planned activities in CCS III

	Implementation targets fully achieved		Implementation targets partly achieved		Implementation targets not achieved		No data/information on implementation

Strategic priority area 1: Advancing UHC			
Outcome 1: Improved access to quality essential health services			
Focus area 1: Health systems strengthening			
Planned activities in the CCS	**Status**	**Specify products and services delivered 2018—2024**	
Strengthened governance, leadership, and coordination in the health sector		•	
Finalization of legislative frameworks, such as the law on blood and blood products		•	
Generation of new data or utilization of existing evidence to make an investment case where needed and advocate for sustainable financing for health		•	
Strengthened coordination and integration of support and interventions to address communicable diseases		•	
Strengthened supply management to ensure adequate diagnostics, medicines and supplies for the prevention and management of communicable diseases at all points		•	
Strengthened IDSR system to address communicable diseases (including neglected tropical diseases and vaccine-preventable diseases), especially targeted ones		•	
Monitoring and tracking health outputs and outcomes		•	
Drug resistance monitoring and provision of guidance for action.		•	
Focus area 2: RMNCH, adolescent health, and nutrition			
Advocacy for more funds to be allocated for maternal health		•	
Improved coverage and quality of maternity and newborn care services, including antenatal care, emergency obstetric care, and elimination of mother-to-child transmission of HIV		•	
Scaling-up of integration of SRH and HIV/AIDS services		•	
Implementation of the Regional Adolescent Flagship Programme to expand coverage of adolescent friendly SRH services			
Integrated school health programme, including a review of school health policy		•	
Training of health workers on new family planning curriculum with a focus on long-acting reversible contraceptive methods, and timely maternal and peri-neonatal death reviews			

Strengthened health sector response to violence against women and children			
Regular review and update of guidance for managing sick children			
Introduction and scaling-up of Care for Child Development			
Improved quality of care for children in referral facilities.			
Focus area 3: Communicable diseases and NCDs			
Ongoing revision of national guidelines for disease control in accordance with global WHO guidance			
Finalization or updating of guidelines for the Expanded Programme on Immunization and IDSR			
Improved quality, coverage and access to services for the prevention, treatment and care of HIV, TB and malaria		•	
Integration of HIV and TB services		•	
Control of drug resistance, including multidrug and extensively drug-resistant TB and antimicrobial resistance		•	
Management of schistosomiasis and other NTDs		•	
Equitable access to public services for the prevention, treatment, and care of NCDs		•	
Advocacy for mobilization and equitable distribution of resources for NCDs, including skilled personnel		•	
Outcome 2: Reduced number of people suffering financial hardship			
Focus area 1: Health financing			
Enhancing the effectiveness of the National Committee in relation to health financing and financial protection within the context of UHC			
Focus area 2: Effective partner coordination			
Strengthened stewardship role of the Ministry of Health and Social Services		•	
Establishment and institutionalization of the health sector coordination mechanism, bringing together all key stakeholders for improved harmonization and alignment within the sector.		•	
Focus area 3: Mobilization and management of resources			
Mobilization of resources for specific programmatic areas, such as RMNCH, adolescent health, and nutrition, NCDs, PHC and health promotion.		•	
Outcome 3: Improved availability of essential medicines, vaccines, diagnostics and devices for PHC			
Focus area 1: Procurement and supply of essential medical products			
Provision of guidance and standards for procurement and supply of essential medicines, vaccines and diagnostics, such as HIV testing kits		•	

Collaboration with other partners providing key support to the Ministry for strengthened procurement, logistics and supply management		•	
Focus area 2: Provision of essential equipment			
Standard setting		•	
Resource mobilization for provision of essential equipment.			

Strategic priority 2: Addressing health emergencies			
Outcome 1: Country health emergency preparedness strengthened			
Focus area 1: Implementation of IHR			
Planned activities in the CCS	**Status**	**Specify products and services delivered 2018—2024**	
Assistance with donor mapping, costing and budgeting for the all-hazards National Action Plan for Health Security		•	
Strengthened disease early warning system and biosafety assessments		•	
Implementation of national risk assessments		•	
Stockpiling for biological, chemical and radiological events		•	
Development and testing of risk communication plan		•	
Strengthened designated points of entry			
Outcome 2: Emergence of high-threat infectious hazards prevented			
Focus area 1: IDSR			
Strengthen surveillance capacity for early detection and response to disease outbreaks		•	
Limit the spread and rapidly contain the risk of emerging and re-emerging epidemics through deployment of vaccines and dissemination of information.		•	
Outcome 3: Health emergencies rapidly detected and responded to			
Focus area 1: Institutional strengthening			
Establishment of the Namibia Institute of Public Health to expand Namibia's capacity for early detection and response to health emergencies		•	
Focus area 2: ICD			
Complete transition from ICD-9 to ICD-10/11.		•	

Strategic priority 3: Promoting healthier populations			
Outcome 1: Determinants of health addressed leaving no one behind			
Focus area 1: Nutrition			
Planned activities in the CCS	**Status**	**Specify products and services delivered 2018—2024**	
Preventing and managing malnutrition, particularly in infants and young children		•	
Evidence-based health promotion and health education programmes at different levels of service delivery		•	
Preventive services, growth promotion and counselling and complementary feeding		•	
Strengthened nutrition counselling within the maternal and child health service		•	
Strengthened Baby-Friendly Hospital Initiative		•	
Finalization and implementation of Code of Breastmilk Substitutes regulations		•	
Participation in multisectoral efforts to address food security and food fortification		•	
Enhanced capacity to monitor food quality and ensure food safety		•	
Focus area 2: Environmental health			
Strengthened partner coordination		•	
Capacity building		•	
Implementation of standards and guidelines		•	
Communication and social mobilization support across programmes		•	
Strengthened capacity to monitor drinking water quality and sanitation		•	
Focus area 3: SRH			
Address harmful cultural practices (such as child, early, and forced marriages) and socio-economic conditions that make Namibian young women and girls vulnerable to sexually transmitted diseases		•	
School health initiatives (including the review of school health policy)			
Outcome 2: Reduced risk factors through multisectoral approaches			
Focus area 1: Physical activity			
Developing policies on physical activity		•	
Creating awareness of the health benefits of physical activity, targeting different groups and settings, including schools, workplaces and the community at large		•	
Advocacy for policy and regulation for improved urban design that is conducive to physical activity.		•	
Focus area 2: Promotion of healthy diets			
Promoting healthy diets in all age groups			

Health promotion and advocacy strategies aimed at increasing consumption of fruits and vegetables, limiting the intake of free sugars and salt (sodium)		•	
Health education programmes to help the population achieve energy balance and healthy weight.		•	
Focus area 3: Substance abuse			
Strengthening of tobacco control measures through capacity development programmes, advocacy, and generation of evidence of efficiency and compliance		•	
Advocacy for adoption of an optional protocol to minimize illicit trade in tobacco products		•	
Drafting and implementation of a tobacco cessation programme		•	
Implementation of strategies to increase levels of awareness on risks associated with tobacco use and second-hand smoking in various settings, including schools and communities		•	
Creation and strengthening of a strong policy and legal environment for prevention of alcohol abuse		•	
Evidence generation on prevalence and risk factors for alcohol abuse.		•	
Outcome 3: Health promotion in all policies and settings			
Focus area 1: HiAP			
Finalization of Health Promotion Implementation Strategy and HiAP Strategy		•	
Capacity development for health promotion across sectors		•	
Focus area 2: NCDs and conditions			
Advocacy for greater prioritization of NCDs		•	
Establishment of a high-level multisectoral coordination body to lead the NCD response		•	
Mobilization of more resources for strengthening promotion of healthy lifestyles.		•	
Focus area 3: Mental illness, injuries and disability, suicide prevention			
Developing and strengthening of national policies, strategies and action plans on mental health		•	
Developing capacity at PHC level to enable provision of non-specialized interventions in mental health care		•	
Implementation of National Decade of Action on Road Safety		•	
Developing and implementing the second National Suicide Prevention Strategy		•	
Strengthening the School Health Programme to include suicide prevention approaches		•	

Strategic priority 4: Strengthening leadership, governance and enabling functions			
Outcome 1: Strengthened data and innovation			
Focus area 1: Research			
Planned Activities in the CCS	**Status**	**Specify products and services delivered 2018—2024**	
Support for operational research, including capacity building			
Facilitating and building linkages between the universities and the Ministry of Health and Social Services to support operational research		•	
Support development of a framework linking evidence to policy and action		•	
Focus area 2: Health information systems			
Support for health information systems strengthening, focusing on building capacity of national data managers and users to strengthen and streamline health information systems integration into the District Health Information System 2		•	
Advocacy and support for a health observatory system to allow access to data		•	
Advocacy and support for relevant platforms, such as websites, to disseminate information		•	
Focus area 3: Monitoring and evaluation			
Integrated monitoring of access to and utilization of health services		•	
Monitoring coverage and evaluation of outcomes and impact of interventions		•	
Support for creating national health accounts and other mechanisms to track health system inputs			
Support systems to monitor the quality of care, especially in private facilities.		•	

Annex 6: Data tables

Population statistics (1)	
Population (2023)	3 022 401 Males: 1 474 224 (48.77%) Females: 1 548 177 (51.27%)
Proportion of population under 5 years	13.7%
Proportion of population aged 5–14 years	23.3%
Proportion of population aged 15–34 years	34.1%
Proportion of population aged 35–59 years	22.0%
Proportion of population aged 60 years and older	6.8%
Rural-Urban distribution	50% urban, 50% rural
Social-economic indicators (2)	
Human Development Index and ranking (2022)	142/193 (0.610) Medium
Inequality Adjusted Human Development Index (2022)	0.399
Gender Inequality Index	0.450
Adolescent birth rate (births per 1 000 women ages 15–19) (2022)	63.1
Health statistics	
Maternal mortality ratio (per 100 000 live births) [95% CI] (2023) (3)	139 [91–223]
Under five mortality rate (per 1 000 live births) [95% CI] (2023) (4)	40.65 [33.02–54.69]
Neonatal mortality rate (per 1 000 live births) [95% CI] (2023) (4)	24.1 [17.76–33.80]
Tuberculosis incidence (per 100 000 population) [95% CI] (2023) (5)	468 [221–622]
HIV new infections (per 1 000 uninfected population [95% CI] (2023) (6)	2.2 [1.8–2.8]
Estimated number of newly infected people (2023) (6)	6 000 [4 900–7 600]
Estimated adult (15–49 years) prevalence of HIV (2023) (6)	9.7% [9.2%–10.2%]
Number of people living with HIV on Antiretroviral Treatment (all ages) (2023) (6)	202 605
Estimated ART coverage (all ages) (6)	89% [82%–98%]
Service coverage	

Proportion of births attended by skilled personnel (2013) *(7)*	88%
Diphtheria-tetanus-pertussis (DTP3) immunization coverage among 1-year olds (2022) *(8)*	84%
Reported number of people requiring interventions against NTDs (2023) *(9)*	387 962
Health systems *(8)*	
Domestic general government health expenditure as a percentage of general government expenditure (2021)	11.24%
Density of medical doctors (per 10 000 population) (2022)	5.43
Density of nursing and midwifery personnel (per 10 000 population) (2022)	33.55
Density of pharmacists (per 10 000 population) (2022)	2.55
Density of dentists (per 10 000 population) (2022)	0.81

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